



Nurses' perceptions regarding providing psychological care for older residents in long-term care facilities: A qualitative study

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Abstract

Aims and objectives: To explore nurses' perceptions regarding providing psychological health care for older residents in long-term care facilities (LTCFs).

Background: Loneliness and depressive symptoms are commonly observed among older residents living in LTCFs. Nurses are expected to provide holistic care including physical, psychological and social care for older residents in LTCFs to fulfil their needs. Therefore, understanding nurses' feelings and thoughts regarding providing care for older residents who feel lonely, sad, unhappy or depressed is important for delivering better care.

Design: A qualitative research design was employed. The Standards for Reporting Qualitative Research (SRQR) was used to enhance for reporting quality.

Methods: Purposive sampling and snowball sampling were applied in Northern Taiwan. One-to-one in-depth interviews were conducted using a semi-structured interview guide. Twenty-one nurses with a mean age of 38.4 years were interviewed. Content analysis was performed for data analysis.

Findings: Four themes were generated from the data: "insufficient psychological healthcare competency," "having a willing heart but not adequate support," "families playing an essential role in residents' mood" and "physical-oriented care model."

Conclusions: Long-term care facilities nurses felt that they were not adequately prepared for taking care of older adults' psychological problems before their nursing career or during their practice. Unreasonable nurse-to-resident ratios and an absence of care consensus among healthcare providers can make nurses feel that they have a willing heart but not adequate support. Family members are essential in older residents' emotional status within the Taiwanese cultural context. Physical care evaluation indicators emphasised by LTCF accreditation resulted in the current care practice model.

Implications for practice: This study provides valuable information for LTCF nurses, managers and directors to develop appropriate strategies to assist nurses in providing better psychological health care for older residents. Evaluation indicators required by LTCF accreditation in Taiwan must be re-examined at the earliest stage.

KEYWORDS

depressive symptoms, feelings and thoughts, long-term care facilities, nurses, older residents, perceptions, psychological health

1 | INTRODUCTION

With the changing family structure, decreasing birth rate and increasing number of women in the labour force, dependent older adults might be more likely to be taken care of by healthcare professionals in long-term care (LTC) facilities (LTCFs) rather than by family members at home. The number of beds in nursing homes in Taiwan increased from 19,511 in 2007 to 41,548 in 2017. The total number of people living in nursing homes increased from 5,207,713 person-day in 2007 to 11,761,757 person-day in 2017, with a 125.9% increase in the past 10 years (Ministry of Health & Welfare, 2018b).

Admission to and living in LTCFs are distressing for older adults because of the institutionalised life and their traditional beliefs. The Chinese culture emphasises filial piety; moreover, the Civil Code in Taiwan addresses relatives to have mutual obligation to care for each other (Lawbank, 2015). Consequently, older adults might easily feel abandoned by their families when they are moved to LTCFs (Tse, 2007), particularly those who did not agree with the relocation decision. Filial piety is crucial in the choice and arrangement of family caregiving (Chen, 2011). Wu, White, Cash, and Foster (2009) reported that the decision of moving from home to LTCFs was a forced choice between older adults and their families. Therefore, in addition to their own health conditions or dependency levels, these beliefs and thoughts may also affect older residents' psychological well-being while living in LTCFs.

2 | BACKGROUND

Older residents experience some negative emotions including loneliness and depressive symptoms, and depression while living in the LTCFs (Choi, Ransom, & Wyllie, 2008; Elias, 2018; Huang et al., 2014; Jansson et al., 2017; Lin, Wang, Chen, Wu, & Portwood, 2005; Neufeld, Freeman, Joling, & Hirdes, 2014). A study reported that 35% of older nursing home residents experienced loneliness (Jansson et al., 2017). The situation becomes worse for the residents without cognitive impairment. A study conducted in Norway found that more than half (56%) of cognitively intact older nursing home residents felt loneliness (Drageset, Kirkevold, & Espehaug, 2011). The evidence has indicated that there was positive relationship between loneliness and depression among older adults (Aylaz, Akturk, Erci, Ozturk, & Aslan, 2012; Domenech-Abella et al., 2017). Thus, depressive symptoms are also commonly observed in individuals living in LTCFs. Recent studies have demonstrated that 19.0%–39.3% of older residents have depressive symptoms or develop depression (Hu, Chuang, Ting, Lin, & Hsieh, 2018; Kval, Bergland, & Telenius, 2017; McCusker et al., 2014).

What does this research add to existing knowledge in gerontology?

- LTCF nurses felt that they were not adequately prepared for providing psychological care for older adults.
- Family members play an important role in older residents' psychological well-being.
- There were few psychological evaluation indicators in long-term care facility accreditations.

What are the implications of this new knowledge for nursing care with older people?

- Appropriate interventions should be designed and developed to improve LTCF nurses' psychological care competence.
- Staffing level and care consensus among healthcare providers are urgent issues that must be re-examined and improved.

How could the findings be used to influence policy or practice or research or education?

- Evaluation indicators required by the LTC accreditation should be re-examined at the earliest stage.
- Further research should focus on examining the feasibility and effectiveness of family involvement in care in LTCFs.

In Taiwan, nurses and nursing assistants are the major healthcare providers in LTCFs. The nurse-to-nursing assistant ratio is approximately 1:3. Nurses are responsible for providing professional care to all residents and also for supervising the work of nursing assistants in the institution. Nursing emphasises holistic care that recognises an individual as a whole. In practice, nurses assess individuals' needs, considering the physical, psychological, social and spiritual aspects (Jasemi, Valizadeh, Zamanzadeh, & Keogh, 2017), to implement appropriate nursing interventions for each individual. Psychological care is part of holistic care and involves identifying individuals' psychological needs and responding to meet them (Priest, 2012). Nichols (2003) described the components of psychological care, which comprise 10 elements, including awareness of psychological issues, patient-centred listening, patient-centred communication, information and education, emotional care, counselling, and support, among three levels. Moreover, traditional Chinese culture strongly emphasises harmonious interpersonal relationships for individual well-being (Yang & Zhou, 2017). Collective accomplishments and

feelings of social value are more important than personal emotions (Chiang, Chien, Lin, Yeh, & Lee, 2013; Yang & Zhou, 2017). Therefore, Chinese older adults might be more conservative in expressing their negative emotions, and compared with Westerners, the reactions and behaviours of Chinese older adults would be more prone to meeting social norms to minimise conflicts. Nurses should consider this cultural difference when providing psychological care, especially for older adults influenced by Chinese culture. Nevertheless, older residents' physical health care is still the main concern among nurses in LTCFs (Chuang & Abbey, 2009). Little is known about difficulties or challenges encountered by nurses while providing psychological care for residents. Therefore, the present study aimed to explore nurses' perceptions regarding providing psychological health care for older residents in LTCFs.

3 | METHODS

3.1 | Research design

The current study employed a qualitative research design involving the use of in-depth interviews to understand nurses' perspectives. The Standards for Reporting Qualitative Research (SRQR) (O'Brien, Harris, Beckman, Reed, & Cook, 2014) was used to enhance for reporting quality.

3.2 | Research settings and participants

Purposive sampling and snowball sampling were used to recruit participants from LTCFs in Northern Taiwan. One-to-one in-depth interviews were conducted using a semi-structured interview guide. We included nurses who (a) were aged ≥ 20 years, (b) had worked in LTCFs for more than 3 months and (c) could communicate in Mandarin or Taiwanese. We excluded nurses who were part-time employees in the institutions. After data saturation had indicated that no new code had occurred in the data (Saunders et al., 2017), 21 nurses from eight LTCFs were interviewed.

3.3 | Data collection procedure

The nurses were approached individually and invited to participate in the study on a voluntary basis. Informed consent was signed by the nurses before the interview. All interviews were conducted in quiet and private locations by one author, and the interview time was arranged according to the participants' schedule. Digital recording was used throughout the interview process after obtaining the permission of the participants. Questions asked during the interview were according to the semi-structured interview guide (Appendix S1). Handwritten notes were made during each interview to record the participants' non-verbal expressions and body language. Each participant was interviewed once, and the interview time was 38–157 min (mean = 60.04). A recorded interview was transcribed verbatim by a hired transcriber 72 hr after the interview. Data were collected from March 2016 to 20 July 2016.

3.4 | Data management and analysis

Data collection and analysis were conducted concurrently. Content analysis was used to analyse data (Graneheim & Lundman, 2004; Krippendorff, 2013). After the author who conducted interviews read the transcripts several times, the meaning units and condensed meaning units were identified. Coding was performed by abstracting the condensed meaning units, and categories were created by grouping codes. Finally, themes were generated by threading categories that shared a commonality. Verbatim interview transcripts were converted to a format accessible by the NVivo 11 qualitative computer program (QSR International Pty Ltd, Doncaster, Australia) for facilitating data management.

3.5 | Rigour of the study

Four general criteria of trustworthiness, namely credibility, transferability, dependability and confirmability (Lincoln & Guba, 1985), were used to examine the rigour of the study. Reflection notes, qualified researchers who had undergone qualitative research training and peer debriefing by two authors were included to enhance the credibility of findings. Detailed information regarding research settings and participants was used to address transferability. For dependability, an in-depth methodological description was used. Moreover, a decision trail, including the description of the research process and data analysis and was documented and maintained for future audits, was used to ensure the confirmability of the study.

3.6 | Ethical considerations

This study was the second phase of a three-year project and was approved by TMU-Joint Institutional Review Board (IRB) (N201512035). All the participants' rights were protected by abiding with the requirements of the IRB.

4 | FINDINGS

4.1 | Participant characteristics

All 21 participants were female (average age, 38.4; standard deviation [SD]=10.73 years). Of them, 15 (71.4%) had a bachelor's degree or higher. The average durations of total nursing experience and nursing experience in LTCFs were 11.62 ($SD = 8.43$) years and 6.02 ($SD = 4.47$) years, respectively. Eleven nurses (52.4%) worked in hospital-based LTCFs. The number of beds of nurses employed was between 40 and 232 (Table 1).

4.2 | Themes

Four themes were generated from the data: "insufficient psychological healthcare competency," "having a willing heart but not adequate support," "families playing an essential role in residents' mood" and

TABLE 1 Characteristics of participants (N = 21)

Participants	Age	Education level	Years of nursing experiences (year)	Years of nursing experiences in LTCFs (year)	Ownership type of LTCFs	Number of beds in LTCFs
01	56	University	18.1	10.2	Freestanding	40
02	48	University	25.6	17.0	Hospital-based	59
03	45	5-year programme	22.0	10.0	Freestanding	76
04	25	2-year programme	2.1	2.1	Hospital-based	76
05	40	2-year programme	18.0	9.0	Hospital-based	74
06	27	2-year programme	4.0	3.0	Hospital-based	74
07	30	2-year programme	4.8	2.8	Hospital-based	74
08	26	5-year programme	3.0	3.0	Hospital-based	74
09	48	University	25.1	8.1	Freestanding	54
10	39	5-year programme	11.0	5.0	Freestanding	45
11	30	University	7.0	1.0	Freestanding	232
12	31	University	6.0	5.0	Freestanding	232
13	40	University	13.3	13.3	Freestanding	232
14	39	University	13.7	2.7	Freestanding	232
15	51	Master	12.0	10.0	Hospital-based	76
16	44	Occupational school	6.0	5.0	Hospital-based	54
17	48	Master	26.8	7.9	Hospital-based	74
18	22	5-year programme	1.7	0.3	Freestanding	45
19	23	2-year programme	2.2	1.5	Freestanding	45
20	38	5-year programme	10.0	8.0	Freestanding	45
21	56	University	4.1	2.5	Freestanding	48

“physical-oriented care model.” Each theme had one or two categories (Table 2).

4.2.1 | Insufficient psychological healthcare competencies

The majority of the nurses expressed that they had inadequate knowledge and skills for identifying older residents' psychological health problems and providing the subsequent care. In addition, they indicated that the preceptorship programme was not available in LTCFs.

Being not well prepared

The nurses indicated that older adults' psychological health issues had not been emphasised at school. In addition, the in-service education or training during practice did not focus on this issue.

(There were) few lessons about psychological health care. Most lessons focused on physical care (04, 25 years old, p. 7) (participants' code number, age, and page number of the quotation in transcripts).

School education did provide some superficial information related to mental support or late-life depression in Mental Health Nursing (course name). (However,) it did not provide us richer or deeper knowledge (18, 22 years old, p. 5).

We need to take continuous education (required by government for practicing in LTCFs in Taiwan): Level I, Level II and Level III (different levels of classes). I found there was little (topics) about psychological health care. Look at the program: it only focuses on the current trends, physical care...rarely covers psychological health care (15, 51 years old, p. 6).

There were little about this (psychological health care) in the in-service training. Most people emphasized disease oriented (care) and did not pay attention to this part (06, 27 years old, p. 8).

Lack of preceptor in the institution

In addition to having appropriate knowledge and skills, the nurses believed that it is important to have senior or experienced colleagues to guide, teach or assist them to ensure that they are taking appropriate care or learn from colleagues to take care of residents' psychological needs.

Like JenJen (pseudonym), she was a nurse in the psychiatric ward before, so she knew better about how to talk with older residents (about mental problems) (01, 56 years old, p. 35).

TABLE 2 Themes and categories

Theme	Category
Insufficient psychological healthcare competency	Being not well prepared
	Lack of preceptor in the institution
Having a willing but not adequate support	Unreasonable nurse-to-resident ratio
	Not on the same page regarding care among healthcare providers
Families playing an essential role in residents' mood	Frequency of family visits
	Feeling of being abandoned
Physical-oriented care model	Lack of psychological care evaluation indicators in long-term care facility accreditation

I don't have the experience of dealing with mental health, so I don't know how to face it, Thus, I seek help from senior colleagues. I stayed with them (senior colleagues) to learn how to care while they deal with (the problem). After facing situations many times, I know how to deal with it most of the times
(04, 25 years old, p. 7).

There are more senior nurses during the day shift. There are 2 nurses in the night shift. If the other nurse has a longer duration of nursing experience than me, I will ask her how to do, because I don't know if I am right or wrong
(07, 30 years old, p. 11).

4.2.2 | Having a willing heart but not adequate support

The nurses know the importance of providing psychological care and would also like to pay more attention to residents' psychological problems; however, they were busy in dealing with the routine care mainly focusing on treatment, medication and physical care during their shifts. They also felt that it is not easy to find similar passion among other staff members (they wanted to do more, but other colleagues might not want to make the extra effort) for providing psychological care to older residents. After completing routine tasks required by institutions, there was little care consensus on promoting or dealing with residents' psychological health among healthcare providers.

Unreasonable nurse-to-resident ratio

The majority of the nurses thought that they had heavy workload and were considerably busy during their shifts. The major reason is the unreasonable nurse-to-resident ratio. After completing routine care and some trivial tasks, they do not have the time to pay attention to problems that are not urgent or for which care outcomes cannot be seen easily.

One nurse needs to take care of 22 residents during the day shift. A nursing assistant needs to take care

of 7 residents. Therefore, we cannot stay longer with any resident
(02, 48 years old, p. 9).

Two nurses in one shift for (taking care of) 76 residents. The average number of residents we are responsible for is 35–40, so it is impossible for us to accompany them. The only time we can chat with residents is when we are treating them
(04, 25 years old, p. 5).

One (nurse is responsible) to (take care of) many residents, so it is impossible for me to immediately respond to a resident's call. I might be busy on other tasks and could not leave the task right away. It is impossible for me to spare some time to go to his/her bedside; then, the resident feels unhappy
(12, 31 years old, p. 6).

A nurse is responsible for 50–60 residents (in night shifts). After a medication round, (nurse needs to do) nursing documentations, measure vital signs ... After completing these tasks, it is almost the time to get off work
(13, 40 years old, p. 6).

Not on the same page regarding care among healthcare providers

In addition to a busy schedule, several nurses explained their frustration while providing psychological health care for older residents. Some of their colleagues only want to complete tasks required by the institution because of time constraints. There was a lack of care consensus on providing psychological care among healthcare providers. Therefore, residents' psychological health care was not delivered continuously.

I feel the most challenging are coworkers' views about care. For example, a female resident had a sleeping ritual, and we needed to satisfy her. She wanted to wake up at 4 o'clock. I am more willing to let her get off the bed at 4 am, but my colleagues did not agree with this idea... They suggest it is better to let her get off the bed at 6 o'clock, because it will be too much trouble for her to get off the bed at 4 o'clock
(09, 48 years old, p. 10).

Social workers took care of the resident and made some plans, but they did not tell us and we did not have time to look at the document
(11, 30 years old, p. 6).

I would spend more time with residents on weekends (shift). However, other nurses would not do this except me. I am not in a position to tell them that they should have more sympathy toward residents... Sometimes,

you want to do something (for the residents), but you cannot do it alone and you need your colleague's help. However, your colleague will not cooperate with you, so it is hard to make it happen. Well, it is nothing I can do (15, 51 years old, p. 4-5).

Although we still handover with each other, everyone's lists and priorities (were different) and affect the care we plan to provide for the resident (21, 56 years old, p. 7).

4.2.3 | Families are essential in determining residents' mood

In the Taiwanese culture, families play an important role in supporting each other and taking care of each other. Family networking and interaction might change when older adults move into LTCFs. The frequency of visits and feelings of being abandoned might be related to older residents' negative moods.

Frequency of family visits

Family visits can light an older resident's day in LTCFs. All the nurses mentioned that residents expressed their happiness when their families came to visit or even after they went home. They keep expecting their families' next visits.

Families did not come to visit often, but his house is nearby. He knew his son would come to visit during holiday. Well, it is a sad story. The resident asked the nursing assistant to help him sit on the wheelchair and go downstairs to stay there waiting for his son. I don't know what happened. He fell from his wheelchair and was dead due to internal bleeding. One last thing he did was waiting for his son's visit (03, 45 years old, p. 1).

No matter how long a resident stays (in the institution), they felt sad when their families did not come to visit them (07, 30 years old, p. 3).

Family support is very important. We can tell the difference in residents' mood when families came to visit or not (11, 30 years old, p. 11).

During the beginning of admission to institutions, families would come to visit often... After a period of time, families did not come often, (so) residents began to withdraw (from a lot of activities). "Do you want to get off the bed?" "No, go away, no..." They just did not want to do anything except for lying in bed... They did not want to tell their families that they hoped that the families would come to visit them often. They were worried that they were busy

and would bother them (families). Actually, the residents hoped that the families would come often (19, 23 years old, p. 2-3).

Feeling of being abandoned

The feeling of being abandoned by families was easily seen and felt among older residents.

Although the family did not have time to take care of residents, the residents still think that their family members threw them into nursing homes. Even if their family members visit them every day, they still think this way (07, 30 years old, p. 10).

Sometimes, residents are not willing to stay here. Although I always talk to residents or families before they move into the institution, I still see that some families lie to the residents, such as this is a hospital and not a nursing home (17, 48 years old, p. 1).

She refused to eat because she felt abandoned by their families. She could eat by herself at home, but she completely refused to eat. She used to fast to express her objection (21, 56 years old, p. 9).

4.2.4 | Physical-oriented care model

The majority of the nurses mentioned that physical care was emphasised in the institution, and residents' psychological health care was easily neglected. The underlying reason might be the presence of few psychological care evaluation indicators in LTC accreditation.

Lack of psychological care evaluation indicators in LTC accreditation

LTC accreditation leads the care standard and protocol development and operation in institutions to improve care quality; however, most evaluation indicators in LTC accreditation focus on physical care rather than psychological care. Institutions strongly ask nursing staff to meet LTC accreditation requirements to pass the evaluation. Therefore, a physical-oriented care model is easily observed in LTCFs in Taiwan.

... about the current accreditation, in fact, they did not emphasize this part...do not focus on dealing with older residents' depressive symptoms (02, 48 years old, p. 12).

About depression care, it takes time and efforts. But, the accreditation did not include it and will not give you the credit when you do it. Do you think we still want to do it?... For example, LTC accreditation did not ask us to provide residents' psychological change

records, so why should I do it. Accreditations did not include (evaluating) it (psychological care)
(13, 40 years old, p. 6-7).

5 | DISCUSSION

This study identified four themes for the experiences and feelings of LTCF nurses related to taking care of older residents' psychological health. Most nurses believed that their own psychological care competence for older adults was insufficient. They thought that they were not adequately prepared for taking care of residents' depressive symptoms, depression or other psychological problems before their LTCF career or during their practice, because nursing education and in-service training did not pay much attention to older adults' psychological health. Corroborating the findings of the current study, several studies have reported that nurses' knowledge regarding late-life depression should be improved (Chuang & Kuo, 2018; Davison, McCabe, Mellor, Karantzas, & George, 2009; McCabe, Davison, Mellor, & George, 2008). In Taiwan, LTC worker training courses, which include three stages (Level I, II and III classes), were commenced in 2010 by the Ministry of Health and Welfare (Lu, Chen, Huang, Wu, & Wang, 2018). Level I class (total duration = 18 hours) mainly focuses on the basic knowledge of the LTC concept. Level II class (total duration = 24-32 hours) assists healthcare providers in acquiring professional care competence in their own specialty. Level 3 class (total duration = 24 hours) stresses on service quality improvement through interdisciplinary cooperation (Lu & Chen, 2014). However, all contents of these three classes pay little attention to the psychological health and well-being of older adults.

Senior or experienced colleagues can serve as preceptors, mentors or role models and assist new or junior nurses to provide psychological care for residents. Preceptorship can be beneficial for nurses' professional development (Marks-Maran et al., 2013; Muir et al., 2013). Nurses with more LTC experiences had a higher level of nursing competencies (Chuang & Kuo, 2018; Hsieh & Chen, 2017). Moreover, attitudes can be learned by imitating other nurses (Price, 2015). Guidance by experienced nurses can help new or less-experienced nurses to observe residents' responses and behaviours from a more positive perspective. Thus, if nurses have experienced colleagues to instruct or counsel them, they might have a more positive attitude towards residents' psychological care. Biley (2005) and Priest (2006) have indicated that learning from other experienced nurses during practice is important; however, junior nurses and students should differentiate between good and bad care models (Priest, 2012). Currently, most LTCFs do not have a preceptorship or mentorship programme in Taiwan; therefore, additional research to examine the effectiveness of a preceptorship or mentorship programme in LTCFs is required in the future.

Unreasonable nurse-to-resident ratios and lack of supportive colleagues made the nurses feel that they had a willing heart but no adequate support. Most nurses claimed that they knew they need to

spend more time with residents, to listen to them or to conduct appropriate interventions to improve residents' psychological health, but they did not have time or they could not do this alone. The nurse-to-resident ratio in nursing homes in Taiwan is 1:15 according to The Classification and Establishment Standards of Nursing Institutions (Ministry of Health & Welfare, 2018a), but it is the "nurse-to-bed ratio" instead of the "nurse-to-resident ratio." If the number of staff hired by an institution is equal to the number of beds divided by 15, then the institution is abiding by the law. Therefore, this may not result in an ideal nurse-to-resident ratio. This is the reason several nurses in this study indicated that they needed to care for 22-60 residents. Evidence has shown that a higher staffing level could contribute to better quality of care (Kane, Shamliyan, Mueller, Duval, & Wilt, 2007; Needleman, Buerhaus, Mattke, Stewart, & Zelevinsky, 2002). Thus, this is an urgent issue that must be solved in Taiwan. Similarly, a study determined that both actual nurse staffing levels and nursing home staffing standards were lower than the ideal levels recommended by experts in several countries, such as the United States, the United Kingdom and Germany (Harrington et al., 2012). In addition, a study reported that both Korean nursing home staffing standards and actual nurse staffing levels were lower than those in the United States (Lee, Shin, & Harrington, 2015).

Another concern of the nurses in this study was that their colleagues did not agree with them about the care they provided. The colleagues and the interdisciplinary team could not reach a care agreement; thus, there was a lack of a continuous care plan for residents, particularly for psychological care. Jasemi et al. (2017) argued that many other healthcare professionals did not have adequate ideas regarding holistic care and should be educated about this concept. In addition, a busy schedule and heavy workload make nurses put all their efforts only into completing routine tasks; thus, they do not have energy to perform additional tasks. Furthermore, a long time is required to improve residents' emotional well-being, and the outcome cannot be seen immediately. However, some nurses still thought that they should provide more support and accompany residents, but some did not agree. A recent study found that workplace interpersonal conflicts (WICs) existed in hospitals (Jerng et al., 2017). Among these WICs, disagreements were the most common. Therefore, achieving care consensus among healthcare providers in LTCFs is a problem that should be solved.

An individual's belief and behaviour are explicitly and implicitly influenced by culture. An old Chinese saying, filial piety is the most important virtue, is consciously or unconsciously embedded in most people's mind in Taiwan. Filial piety is similar to a social norm guide that indicates how parents and children should treat each other and regulate their behaviours (Kim & Kang, 2015). A study found that when parents were functionally dependent or had financial problems, respect paid and care provided by children during their illness were the two most important predictors affecting parents' psychological well-being (Cheng & Chan, 2006). The theme "families play an essential role in residents' mood" found in the current study might echo the findings of the aforementioned studies. The relationship between older residents and families, visit frequency and support

might influence the emotional well-being of institutionalised older adults. A recent study revealed that older residents had mixed feelings about living in nursing homes in China (Zhang, 2017). Older residents thought that they could receive better care in nursing homes, but they did not completely accept institutionalised care because of the conflicts of traditional beliefs regarding family care and unmet psychological demands and spiritual comfort in LTCFs. The study also demonstrated that children felt guilty about their parents living in nursing homes and could not provide care to their parents. However, Zhang noted that older residents did not feel unfilial about their children sending them to nursing homes because they believed that their children had no other choice but doing it. Similarly, another study concluded that parents showed their understanding regarding the decision for institutionalisation because they did not want to become a burden on their children (Chen, 2011). However, contradictory feelings existed in older adults' minds. Sometimes, they believed that this arrangement decision was right for them, but sometimes, they still felt that it was not a right choice. Considering the Taiwanese cultural context, involving family members in daily activities and care as well as keeping them in contact with older residents in LTCFs are issues that must be faced and explored in the future study. A practical and effective care method or a protocol should be developed.

A physical-focused care model was discovered in the LTCFs in this study. By contrast, a systematic review reported that nursing home care has transformed from task-focused care and person-centred care to relation-oriented care in terms of considering the needs of residents and other involved parties, such as families and communities, in the past decade (van Stenis, van Wingerden, & Kolkhuis Tanke, 2017). This review included 24 studies, and the majority were conducted in Western countries, such as Sweden, Norway, the Netherlands, the United States and the United Kingdom, and only one study was conducted in an Eastern country, namely South Korea. In the current study, nurses believed that an inadequate psychological indicator in the accreditation of long-term care shapes the physical-focused care model of LTCFs. Nonetheless, accreditation is very important, because it can facilitate nursing homes to improve quality (Wagner, McDonald, & Castle, 2012; Williams, Morton, Braun, Longo, & Baker, 2017). According to Long-Term Care Services Act in Taiwan (Ministry of Health & Welfare, 2017b), the purposes of LTC accreditation are to evaluate the efficacy of LTCFs, increase care quality and provide selection lists for users. The accreditation is held every 4 years (Ministry of Health & Welfare, 2017a). The aspect of evaluation includes administration and management, personal and professional care, environment, residents' rights and protection, and improvement and innovation. Of the personal and professional care, indicators in this aspect mainly focus on physical care including personal hygiene, nursing skill standard operating procedure (SOP), health check-up, infection rate, physical restraint, pressure sores, falls, pain, unplanned admission to the hospital, unplanned weight change, and nasogastric tube or urinary catheter removal. Therefore, a physical-oriented care model is mainly followed in an institution. Adding more indicators related to psychological care should be considered in Taiwan's LTC accreditation.

5.1 | Study limitations

All the institutions were located in Northern Taiwan which may restrict its applicability to other context. However, purposive and snowball sampling used in the current study enabled us to recruit participants from different LTCFs. In addition, all participants were female in the current study; nevertheless, in Taiwan, most nurses in LTCFs are female (97.9%) (Ministry of Health & Welfare, 2017c, 2017d).

6 | CONCLUSIONS

The findings of this study provide insights into nurses' feelings and thoughts regarding delivering psychological health care for older residents in LTCFs. Nurses felt that they were not adequately prepared for taking care of older adults' psychological health problems before their nursing career or during their practice. Unreasonable nurse-to-resident ratios and absence of care consensus among healthcare providers can make nurses feel that they "have a willing heart but not adequate support." Family members are essential in older residents' emotional status within the Taiwanese cultural context. Physical care evaluation indicators emphasised by LTCF accreditation resulted in the current care practice model. The results not only fill gaps in nursing knowledge but also provide crucial information for LTCF nurses, managers, directors and policymakers. In addition, the findings provide valuable information for nursing faculty members to develop or design related courses. Finally, this study can be a solid base for future research.

Relevance to clinical practice

- School education and continuous training courses by institutions or the government should consider including older adults' psychological care. Future studies should evaluate the feasibility and benefits of the preceptorship programme in LTCFs. The staffing level and care consensus among healthcare providers are urgent issues and must be re-examined and improved. In addition, support and association between older residents and their families might be related to older adults' psychological health in LTCFs in the Taiwanese context, but more research exploring the relationship between these two variables is required. Psychological evaluation indicators, such as rate of change in older adults' depressive symptoms, should be added to LTC accreditation.

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CONFLICT OF INTEREST

No conflict of interest is declared by the authors.

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