

Autonomy in long-term elderly care

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Elderly people are a vulnerable group in the society due to their decreased health condition. For this reason, they are often dependent on care services and entering a long-term care institution is also a difficult challenge for them. In institutional care, numerous factors affect the self-determination and autonomy of the elderly residents. Autonomy in long-term care is a very important aspect in the lives of the elderly people.

The purpose of this study is mainly to investigate the autonomy of the elderly in long-term care based on the theories of self-determination and autonomy. The study aims to address two research questions. First, which factors mostly affect the autonomy of the elderly in long-term care? Second, what kind of opportunities the elderly people have to exercise their autonomy in long-term care? In this study, a non-systematic and traditional literature review method has been applied. Electronic databases were used for data collection, which were then analysed by employing the abductive content analysis approach.

The study found five different factors which affect the autonomy of the elderly in a long-term care. These include freedom to choose, dependency, dignity, paternalism and frailty or disability. The study also found a few opportunities that can help exercise autonomy in long-term care settings. Such opportunities include proper opportunities to use self-management abilities, addressing and digging out the capability of older residents and changing the view of caregivers to the vulnerable elderly. Future studies should explore the capacity and ability of the elderly with severe mental impairments. To improve the well-being of the elderly, we need to know more about the policy and regulations of different care settings as well.

Keywords: Elderly, autonomy, long term care, dependency.

Contents

1 Introduction	5
2 Theoretical background	7
2.1 Self-Determination Theory (SDT) and Autonomy	7
2.2 What is autonomy?	8
2.2.1 Aspects of autonomy	9
2.2.2 Values of autonomy	11
2.3 Summary of theoretical background	12
3 The purpose of the study	13
4 Methods	14
4.1 Methods of the study	14
4.3 Data Analysis	16
4.4 Ethical consideration	17
5 Autonomy in long-term care	18
5.1 Factors mostly affect autonomy in long-term care	18
5.2 Opportunities for exercising autonomy	20
6 Conclusion	22
7 Discussion	38
References	41

List of tables:

Table 1: Data searching process.....	15
Table 2: Real data (accepted data)	15
Table 3: Factors of autonomy.....	17
Table 4: Opportunities for exercising autonomy.....	20

List of Pictures:

Pic 1: Self-determination and human's three basic needs.....	8
Pic 2: Aspects and values of autonomy according to earlier studies.....	13

1 Introduction

People, generally speaking, are living much longer nowadays. Also, the life expectancy in the older population itself is growing. As a result, worldwide the number and proportion of the elderly population is rising day by day (National Institute on Aging, 2016). This has made us concerned on the care of older people. Because the present state of the older people is potentially our tomorrows. Older people in general are vulnerable because of their loss of control and ageist attitudes. Once they start their lives either in a hospital or in an age-related residential care service their vulnerability increases significantly. This is true both in the developed and developing world. In such situations, emphasis on matters of ethics is specifically needed in order to handle vulnerability-related consequences and other circumstances properly (Rees et al. 2009).

By definition, nurses in an elderly care service are a group of healthcare professionals who are in charge of the day-to-day care of older patients. However, they occasionally meet ethical challenges in their regular work with the elderly populations in many healthcare settings. Care approaches and patient-practitioner relationships are of different types and ethics in nursing is made explicit in all care approaches. Therefore, better understanding of the ethically difficult situations is vital and for that purpose, discussion on the ethical questions concerning older people's nursing is required. However, it is not always easy to initiate discussion on all the ethical aspects associated with care services (Suhonen *et al.* 2010).

Providing nursing care to an older person involves more than catering for physical needs. It also requires an understanding of the psychological, sociological, cultural and ethnic needs of a person who has lived through losses and adversity as well as good times. In fact, ageism is probably the major source of ethical issues in the care of older patients. Fundamental changes in attitudes towards the older people in our society are therefore clearly required. One way to change such attitudes towards the ageist is through awareness and education (Morris 2005).

Applying ethical practices in caring for older people is clearly a vital issue for the following reasons. First, situations and issues in the care of older people which are ethically difficult have been recognised. Second, for different groups—such as, health professionals, patients and their relatives—there are clear differences in perceptions on ethical issues. Third, findings on research studies demonstrate that the ethical climate in healthcare environments is not quite good and often, underestimates older patients. Finally, high ethical standards of nursing care can be ensured through increased awareness of ethical issues in the care of older people. Moreover, older people, in particular, are a vulnerable group in the society with special health complications. For instance, entering a care institution is one of the most difficult challenges for them, which may lead to more dependency on the staff (Boyle 2008).

In institutional care, how the staff behaved, which words they used and the attitudes they had towards the elderly residents are important. Respect, for instance, is very much important when elderly individuals receive any help they needed. Some studies have discussed the elderly health status and how the influence of others significantly affect the self-determination or Autonomy of these residents. In this connection, the number of the staff, institutional schedules and routines are the major factors which are mentioned in many studies. Declining cognitive abilities are directly related to freedom of choice. When the elderly people are more dependent on the health care personnel, their freedom of choice also becomes restricted (Morris 2005).

Old age is commonly meant for dependency. Again, dependency, which is related to impairment, is frequently equated with vulnerability, inactiveness and loss of autonomy (Morris 2005). Patients have the right to choose, accept or decline information. Health professionals and concerned others are obliged to ensure this right. Therefore, forced information, forced choice and a disclosure which is evasive in nature are inconsistent with such obligation. In this context, however, one delicate question arises here: is it always possible to inform patients of their rights to know and to decide without compromising their systems of belief and value? Is it always possible to do this without disrespecting them? Health professionals should never assume their patients' wishes to receive information. The reason is that a patient belongs to particular person's autonomous choices. Hence, health professionals continuously try to know about their patients' wishes to receive information and to make decisions accordingly. From this point of view, therefore, in health care respect for autonomy is a professional obligation, not ideal. But, autonomous choice is a right which is not a duty of patients (Beauchamp & Childress 2001).

The concept of autonomy requires that a person is perceived as a sensible being who makes considered moral choices. In many care professions, patients' dependence may appear to be referred to more often than their independence. The focus of care is usually directed towards patients' strong dependence on help from others. On the other hand, nurses who provide care services for elderly people often encounter ethically difficult situations that create frustration and stress in their everyday working life. It is very common that nurses are trained to take respect and self-determination into account. But, it is very difficult to balance between self-determination and dignity of their patients when some patients cannot meet their own needs in everyday life. Sometimes health workers experience ethically difficult situations. Especially in situations in which they sometimes have problems knowing what is the right and appropriate action to take. The most difficult situations are often associated with the care for older people with dementia where ability for abstract and reflective thought is reduced to varying degrees (Morris 2005)

So, ethical practices in long term elderly care are vital issues. Care practitioners often face difficulties when they try to balance between residents' rights and their care needs, particularly for the vulnerable elderly. In the theoretical background section of my study, I would like to focus on autonomy where autonomy is explained in more detail to provide a clear vision of how care

practitioners can fulfil the residents' rights and needs without disrupting their autonomy. Theoretical background part starts with descriptions on the self-determination theory where autonomy is one of the major needs. Often autonomy and self-determination terms are used synonymously.

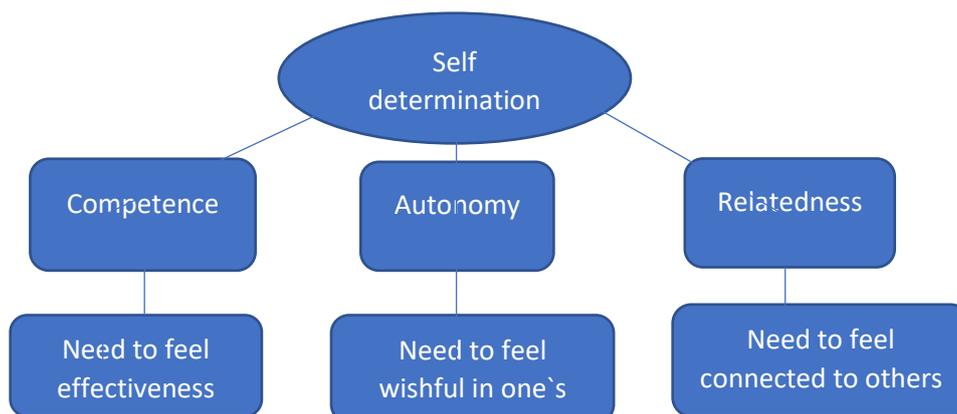
2 Theoretical background

2.1 Self-Determination Theory (SDT) and Autonomy

Self-determination is often used synonymously with autonomy as no clear-cut definition of self-determination is available in the literature (Elander 1989; Rynning 1998). In health care, however, self-determination is described as patients' participation in the decision-making process which affects their lives. But such participation should be without constraints imposed by others (Kloezen, Fitten & Steinberg 1988). Self-determination was introduced in 1985 in the Medical and Health Service Act (31). This emphasizes the importance of respects for patients' self-determination and integrity so that health services must ensure the requirements of good care (Eklund, Dahlin-Ivanoff & Eklund 2014).

The self-determination theory is defined as a model of motivation and personality. The theory is actually based on the narrower conception of human needs. To be specific, the self-determination theory aims to justify three crucial psychological needs: the psychological needs for autonomy, competence and relatedness. Environmental and interpersonal factors have been perceived to meet these needs. These factors maintain and enhance the self. However, the factors that frustrate or block need satisfaction essentially foster ill health, conflict and distress. Self-determination theory, developed by Deci and Ryan (2000), is clearly a psychological approach to explain human behaviour. In accordance with this theory, typically people's experience is considered to be the main determinant of action.

The theory basically focuses on how people interpret internal or external stimulus inputs. Such interpretations get meaningful through their direct or indirect link to people's basic psychological needs (Deci & Ryan 2008). SDT also highlights human nature. Indeed, psychological needs are the basic aspects of the psychological architecture of the human organism. So, such needs are natural. Again, since psychological needs are applicable to all individuals irrespective of gender, background and culture, such needs are universal as well. Relevant features of the self-determination theory can be explained by the following self-explanatory flow diagram (Picture 1).



Picture 1: Self-determination and human`s three basic needs

The SDT is centred around three major needs that human beings are interested in: competence, autonomy and relatedness. A need for competence reflects the need to feel effectiveness in efforts and being capable of achieving desired outcomes. The need for relatedness involves the need to feel connected to and understood by others. Finally, the need for autonomy reflects the need to feel wishful in one`s actions, to fully and authentically endorse one`s behaviours and to act as the originator of one`s own behaviour (Deci & Ryan 2000). A brief discussion on autonomy is provided below as follows.

2.2 What is autonomy?

In Greek ‘autos’ means self and ‘nomos’ means governance or law. The word “autonomy” in English is actually derived from these two Greek words. The word ‘autonomy’ nowadays has been extended to individuals as well. Today, the word has acquired diverse meanings like, for instance, self-governance, liberty rights, privacy, individual choice and freedom of the will. Personal autonomy is on type of self-rule. Personal autonomy in that sense is free from both controlling interference by others and from limitations. These limitations include inadequate understanding, and due to such limitations making meaningful choices might be prevented. As independent governments are able to manage their own geographical territories and to set their own policies accordingly, autonomous individual acts freely according to a self-chosen plan (Rossello 2002).

According to Rossello (2002), autonomy is defined to be made of many levels. Rossello (2002) points out different interrelated realities, which are as follows: 1) autonomy, where external constraints are unavailable; 2) autonomy, where individuals have the freedom to choose; 3) autonomy as a choice

where an informed consent is rational; and 4) autonomy as a choice where individually chosen particular moral values have been acknowledged.

The concept of autonomy in moral philosophy and bioethics recognizes the human capacity for self-determination. Autonomy thus describes a principle that the autonomy of persons should be respected (Miller 1995). In this connection, three elements to the psychological capacity of autonomy are important to note: agency, independence, and rationality. Agency is basically awareness of one's desires and intentions and acting on them. Independence is the absence of influences. With someone's control in place, what a person does is not necessarily something that he or she wants to do (Miller 1995). Finally, rationality, is synonymous to "rational decision making" (Miller 1995, 216).

Essential qualities of an autonomous person have been elaborated in the theories of autonomy. According to such traits or qualities, an autonomous person should have the capabilities related with self-governance. For example, he/she should have the ability of understanding, reasoning, deliberating and independent choosing. However, owing to temporary constraints caused by illness or depression, or because of other conditions that restrict their options like ignorance, coercion, autonomous persons with self-governing capabilities sometimes may fail to govern themselves in particular choices (Beauchamp & Childress 2001).

2.2.1 Aspects of autonomy

Rossello (2002) highlights two aspects of autonomy. Firstly, autonomy suggests human's ability to develop. Such development is a depiction of the ends of human's life and of the means to achieve them. Autonomy is also to act without any external constraint according to this depiction. Thus, autonomy allows people to want something as they wish and to act knowingly and willingly. Secondly, autonomy is the independence of doing what one wants to do consistent with the social and political circumstances and according to one's strengths. In that sense, autonomy consists of human's capability of choosing a way of thinking. Autonomy also allows people to be free of individual morals and duties in relation to some areas of life (Rossello 2002). In this connection, we can take a note of subjective autonomy which consists of two completely separate dimensions: decisional and executional autonomy (Collopy 1995).

Collopy (1995) describes decisional autonomy as the decision-making capability that enables someone to develop personal choices and values, regardless of having the ability of carrying them out independently. However, Collopy (1988) designates decisional autonomy as an equivalent to self-determination. On the other hand, Beauchamp and Childress (2001: 58) analyze "autonomous action in terms of normal choosers who act (1) intentionally, (2) with understanding, and (3) without controlling influences that determine their action".

Decisional autonomy in the bioethics literature is dissimilar to the concept of autonomy suggested by Faden and Beauchamp (1986). Their theory covers three aspects of autonomous action: understanding, intentionality and voluntariness. In the autonomous action of understanding, with adequate knowledge of the situation and available options, a patient also has an appreciation of how these affect his or her personal level. The patient shows appreciation by demonstrating some rational process for assessing options and choices and how these option or choices can be applied in his or her own circumstances. However, they might also make unconventional or even unreasonable choices sometimes. Intentionality, the second autonomous action, requires that the patients' actions are initiated and performed according to his or her goals and plan. Voluntariness, the third aspect, prevent the patient's voluntary actions or compel involuntary actions. This may happen due to coercion or manipulation and internal impairments like hearing loss, pain or unreasonable fear.

Other people must provide 'decisional autonomy' every time patients' capacity for such autonomy is diminished or lost. Decisional autonomy indicates the moral dimensions of caring for older people. So, health care professionals must recognize personal autonomy even when a certain degree of decision-making needs to be transferred or delegated (Collopy 1988).

Executorial autonomy basically means the exercise of autonomy (Collopy 1995). Its importance becomes apparent with the shift from acute care to chronic care. In acute care the patient authorizes and the clinical team executes a plan of care, whereas in chronic care the patient authorizes and then plays a vital role in executing the plan of care. Here, executive function of the patient is subsumed under his or her cognitive abilities for decision making, but very little explicit reference is made to the dimensions of formulating, executing and adapting his or her implementation plans (Naik et al. 2006).

However, even if physically disabled older people are often autonomous in terms of taking decisions they are generally regarded as non-autonomous. Besides, people with dementia or depression may be unable to implement their decisions and for that reason usually need help for making decisions. In an early study, Doyal and Gough (1991) argued that autonomy and physical health are the fundamental needs of human beings. Nevertheless, absence of physical health or functional capacity among the older people do not necessarily become a barrier to their autonomy. Consequently, it may so happen for some older people with dementia or depression that there is practically no minimum threshold level of autonomy. However, as Boyle (2008) argues dementia affected older people should have the ability of applying their existing capacity for autonomy. This can show how they are able to utilise their existing cognitive abilities and sense of activeness.

Evidently, damages of intentionality or voluntariness can be regarded as impairments of executive autonomy. This type of impairments is sort of threat to the capability of the patient to follow a mutually agreed treatment plan. Impairments of executive autonomy can occur independently of decisional autonomy. They can occur with impairments of decisional autonomy too. This is frequently observed among the vulnerable older adults who has noticeable impairments of executive autonomy

that possibly arise from multiple deficits. Such type of vulnerable older adults may come to the attention of local adult protective agencies as they are unable to live safely and independently (Naik et al. 2006).

Understanding mostly depends on oral and hearing communication and memory. Some functions are related to attention, acquisition and processing of sensory data, while some are basic cognitive functions, including reasoning and aspects of judgment (Grimes et al. 2000). In contrast, intentionality and voluntariness are much more strongly related with executive control functions. Such functions include the cognitive skills required to plan, initiate, sequence, monitor and adapt complex goal-directed behaviours as well as the important connections among affect, motivation and behaviour (Grimes et al. 2000; Workman et al. 2000; Royall et al. 2002).

2.2.2 Values of autonomy

Arguably, autonomy is valued for the value of the right to self-sovereignty. It involves the claim that people themselves know best their own well-being. Therefore, it is in their best interest to make choices for themselves (Schermer 2001). A person's wishes are always in his/her best interest because his/her 'good' is determined only by his/her own preferences and desires. Although people are not the perfect always, but they are the best judges of their own well-being. From the subjectivist standpoint, a person's wishes and his best interest will always coincide. From this perspective, if a person makes his/her own choices it is always in his/her best interest. This implies that although a person can make mistakes in judging his/her own well-being, it is impossible for others to correct them or to know them better. So, even if a person himself is not the perfect judge of his own best interest, there is no better judge than he is. From this interpretation, it follows that allowing a person to make his/her own choices is the best possible, though not the perfect, way to promote his interests. Both these positions seem implausible, however, since we normally recognise situations in which people make choices that are not in their own best interest, or in which others are in a better position to judge what will be in a person's interest.

Some instrumental value arguments claim that autonomy promotes well-being and should be valued for that reason, but only to the extent that it is indeed conducive to well-being. The right to self-government can also be valued, however, because it protects the capacity for and condition of autonomy. The value of autonomy as a capacity and a condition is then explained by intrinsic value arguments. Intrinsic value arguments show how autonomy is closely linked to a number of other concepts that we value, such as being a person, having an identity or having one's own life. It is also important because it is conducive to self-respect and is a basis for the mutual respect we owe each other.

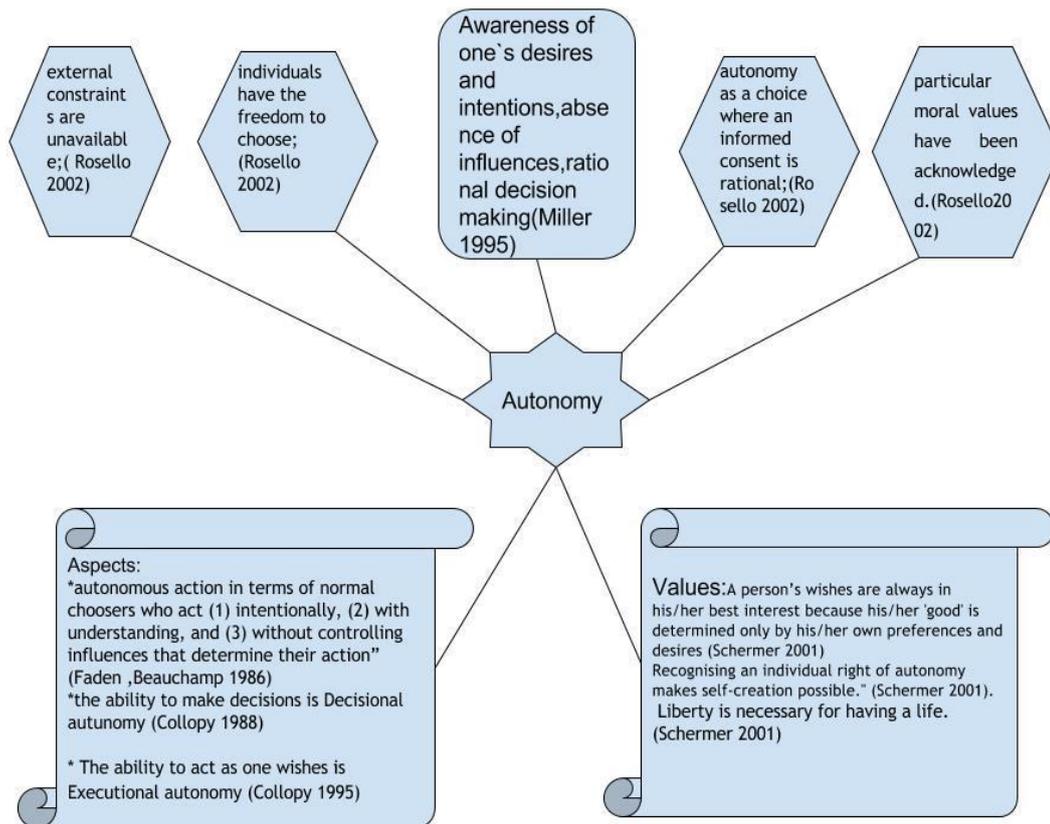
The right to autonomy protects or even enhances autonomy in these senses. "The value of autonomy derives from the capacity it protects: the capacity to express one's own character—values, commitments, convictions, and critical as well as experiential interests—in the life one leads. Recognising an individual right of autonomy makes self-creation possible" (Schermer 2001). Liberty is necessary for having a life. 'A life' refers not to the biological notion of being alive but to the biographical notion of leading a life with intentions and plans, making decisions and acting upon them are the essential features that define a life. Someone who is a 'total slave', who has no liberty at all, in action nor in thought, cannot have a life in this sense; such an individual is not the subject of a life (Schermer 2001).

The exercise of autonomy is what makes a person's life his own. Recognising others as distinct selves, as persons, makes it possible to take a moral point of view and serves as the basis for moral respect. "Moral respect is owed to all because all have the capacity for defining themselves". According to Dworkin, we have a conception of persons that is deeply rooted in our world view and which is worthy of respect and admiration. The conceptions—or rather the ideals—we hold of persons and of human life require us to value and respect autonomy. The concept of autonomy enables us to express our respect for persons and their distinctly human capacities, and this is fundamental for our moral relationships to one another (Schermer 2001).

In order to understand the meaning of autonomy in relation to a disabling condition (such as frailty), a distinction between decisional autonomy (the ability to make decisions without external restraint) and executional autonomy (the ability to act as one wishes) should be made. Executional autonomy is dependent on decisional autonomy, but not the reverse, and it is essential to distinguish between decisional and executional autonomy, especially in the care of frail older people (Ekelund et al. 2014).

2.3 Summary of theoretical background

Based on earlier literature, in this study Autonomy means following principles, aspects and values (Picture 2).



Picture 2 Aspects and values of autonomy according to earlier studies

3 The purpose of the study

Elderly people are a vulnerable group in the society due to their decreased health condition. For this reason, they are often dependent on care services and entering a long-term care institution is also a difficult challenge for them. In institutional care, numerous factors affect the self-determination and autonomy of the elderly residents, for example, declining cognitive abilities are directly related to their freedom of choice where elderly with dementia and depression are unable to make their own decisions. Dignity and respect are very important when receiving care from the staff, institutional routines and schedules also affect elderly people's wishes and choices. In the health care sector, respect for individuals' autonomy is a right.

Thus, we see that autonomy in long-term care is a very important aspect in the lives of the elderly people. Therefore, the purpose of this study is mainly to investigate autonomy of the elderly in long term care on the basis of the theories of self-determination and autonomy.

Research questions of the study are:

1. Which factors mostly affect autonomy of the elderly in long term care?
2. What kind of opportunities the elderly people have to exercise for their autonomy in long term care?

4 Methods

4.1 Methods of the study

In this study, a non-systematic and traditional literature review method has been applied. Electronic databases were used for data collection and after collection of the data, they were analysed by employing the abductive content analysis approach. This process is described as follows.

Two types of literature review methods applied in this research: traditional literature review method and non-systematic literature review method. By traditional literature reviews, we get valuable summaries of relevant literature on a wide range of topics. Mostly conducted by the experts in the field, these narrative reviews are valuable as they usually present a general overview on the topic (Petticrew & Roberts 2006). But one of the limitations of such narrative reviews is that they are influenced by their preferred theories, needs and beliefs. Also, commonly they are not directed by a stated question, rather they are driven by a general interest in a topic (Petticrew & Roberts 2006:6). Therefore, the process of extracting relevant information is not explicit and clear summary based on studies can be influenced by reviewer's theories of needs and beliefs. This is particularly true when specifying the quality of the included papers is difficult.

Therefore, a non-systematic literature review approach is also applied in this research. By using this type of literature review method, the author tries to compare and contrast different authors' views on an issue. The author also tries to highlight the gaps of the research, disagreements, if any, among the writers and how different studies are related with one another. So, in this case, the author needs to define and limit the problem based on relevant literature.

4.2 Data collection

To identify articles for the review, a search of the databases was conducted. Different search terms were used. The use of the term ab ensures that only articles with a separate abstract are collected. The search was limited to English language only and time limit mentioned below. A citation was excluded from the analysis if: (1) the study focussed on a context other than nursing care, a nursing

situation or a nursing intervention; (2) the target group of the study was not an older or aged population; and (3) the study did not investigate ethical concepts. This review is therefore concerned with publications that: (1) focus on nursing care situations; (2) focus on care for older people and use older people, their relatives, care givers, managers or students from settings providing care for older people as informants; and (3) focus on ethical concepts.

Table 1: Data searching process

Databases	Terms, Keywords	Limitations	Results	Articles chosen	Accepted
Cinahl/Ebsco	1. Elderly OR aged OR senior OR older people AND patients Autonomy AND Long-term care	15 years, Academic journals, full text	75	25	7
PubMed	1. Elderly care AND Dependency AND Autonomy 2. Disability and Autonomy AND Long-term care	15 years, full text, Academic journals	312	23	8
Sage	Aged AND Long-term care AND autonomy AND disability	15 years, full text, research articles	92	17	5
ProQuest	Long term care AND patient autonomy AND aged	15 years, full text, scholarly articles	45	6	1

Table 2: Real data (accepted data)

Name of the article	Year	Writers	Main criteria for accepting the article
Dependence and Autonomy in Old Age. An Ethical framework for long-term care.	2003	Agich, G. J.	Factors that affect elderly autonomy
Ethical issues in the introduction of case management for elderly people	2012	Corvol et al.	Factors that affect elderly autonomy
Perceptions of Long-Term Care, Autonomy, and Dignity, by Residents, Family and Care-Givers: The Houston Experience.	2007	Boisubin et al.	Elderly wishes in long term care settings
Self-determination and older people - A concept analysis.	2014	Eklund et al.	Factors that affects elderly autonomy
Perceived Autonomy and Activity Choices Among Physically Disabled Older People in Nursing Home Settings: A Randomized Trial.	2009	Andresen et al.	Opportunities to exercise autonomy
Elderly people's perceptions of how they want to be cared for: an interview study with healthy elderly couples in Northern Sweden.	2009	Harrefors et al.	Elderly wishes in long term care settings
Everyday Ethics in The Care of Elderly People.	2006	Bolmsjo et al.	Care ethics

Dependency, Difference and the Global Ethic of Long Term Care.	2005	Kittay et al.	Old age dependency and care
Making Care Decisions in Home-Based Dementia Care: Why context Matters.	2012	Amant et al.	Opportunities to exercise Autonomy
Autonomy and integrity: upholding older adult patients' dignity.	2004	Randers	Factors That affect elderly Autonomy
Physical restraint in institutional elderly care: forms of restraint, frequency of use and reasons for use.	2007	Saarnio	Autonomy and care ethics
Dependence, independence or inter-dependence? Revisiting the concepts of "care" and "dependency"	2005	Fine et al.	Basic care Ethics
Care for Older People—A concept analysis of autonomy for older people in residential care	2009	Welford et al.	Autonomy and disability
Nurses' Perceptions of Ethical Issues in the Care of Older People	2009	Rees et al.	Institutional routine care
Experiences of self-determination by older persons living in sheltered housing	2007	Hellstörn et al.	Institutional routine care
Facilitating choice and control for older people in long-term care	2004	Boyle	Opportunities to exercise Autonomy
The role of autonomy in explaining mental ill-health and depression among older people in long-term care settings	2005	Boyle	Opportunities to exercise autonomy
"Autonomy in long-term care: a need, a right or a luxury?"	2008	Boyle	Autonomy and dependency
Dignity of older people in a nursing home: Narratives of care providers	2010	Jakobsen et al.	Institutional routine care
Do nurses exercise power in basic care situations?	2003	Palviainen et al.	Paternalistic behavior
Old or Frail: What tells us more?	2004	Schuurmans et al.	Elderly and frailty

4.3 Data Analysis

Content analysis research method, also known as a method of analysing documents, is a systematic and objective way of describing and quantifying phenomena (Krippendorff 1980; Downe-Wamboldt 1992; Sandelowski 1995). For better understanding of the data, content analysis allows the researcher to test theoretical issues. Through content analysis, researchers aim to distil words into fewer content related categories. When words and phrases are classified into the same categories, they presumably share the same meaning (Cavanagh 1997). Again, Krippendorff (1980) defined content analysis as a research technique that makes replicable and valid inferences from data to their context. The purpose of such references is to provide knowledge, new insights, a representation of facts and a practical guide to action. In this study, however, a deductive content analysis has been used to analyse the data as this approach is more related to the nature of the research.

An abductive analysis is basically centred on the relationship among theory, method, and observation. Such analysis therefore summaries how causal accounts are constructed and what are their

limitations. It also describes how forms of variation, observation and theorization are linked with one another. In any field, however, the explanations and categorization used by the social scientists may be different from those prescribed in an abductive analysis. So, abduction essentially denotes a creative inferential process that aims to produce new hypotheses and theories based on uncommon research evidence. In that sense, abduction comes up with an innovative hypothesis for which one may need to collect more observations on a topic (Tavory & Timmermans 2014).

Thinking theoretically, abduction aims at beginning its observations without assumptions and, above all, without theories (Reichertz, J. 2013). Abduction is also a logical way of creating fresh ideas, and not to follow the conventional views. In abduction, one needs to decide reasonably with sufficiently thoughtful awareness. Abduction, therefore, comes up with several creative outcomes and new ideas combining different features. However, such combinations, though may always not be obligatory, are often found to be risky. Hence, abduction moves forward from, for example, one known quantity (i.e., result) to two unknown features (i.e., rule and case). Therefore, in essence, abduction is an intellectual process and a mental act, that associates usually non-connected things. It is therefore an intellectual way of finding.

4.4 Ethical consideration

For ethical consideration GAO (1996) notes that the analysis process and the results should be described in sufficient detail to provide the readers a clear understanding of how the analysis was carried out and what were the strengths and limitations of the study. This essentially highlights the importance of separation of the analysis process and the validity of results. Again, fundamentals of validity in content analysis are universal to any qualitative research design. There are also some extra issues that researchers need to take care of while reporting the process of analysis and the results of the study. In this case, the results are described as the contents of the categories, *i.e.*, the meanings of the categories. Again, the content of the categories is then defined through subcategories (Marshall & Rossman 1995). The above points are vital to any research and therefore, these factors are well taken into consideration while conducting this study.

5 Autonomy in long-term care

5.1 Factors mostly affect autonomy in long-term care

Based on content analysis, this study finds that freedom of choice mostly affects the autonomy in long term elderly care. If opportunities to make own decisions decrease, the possibility to act intentionally decreases too, as decisions are controlled and made by other care staffs and relatives. Although due to dependency, elderly move to the institution, this study found that absence of proper understanding and acknowledging individual's moral values increase dependency in long term care. So, possibility to act as an independent and keeping the power of self-reliance decrease. Thus, increased dependency is found as the second factor which affects the autonomy in long term care. Dignity is found as a third factor which affects the autonomy in long-term elderly care. Care staff's insufficient attention to address the elderly individual as a human being and properly addressing individual's personality affect the dignity and at the same time it also affects the autonomy of elderly care. Paternalism, which is most common in long term elderly care, is found to be the fourth most important factor which affects the autonomy. Though some institutions practice paternalistic behaviour to prevent harm and minimize risk due to refusal of care and refusal to eat, this practice is also a debatable issue. It is related with how care staffs are respecting individual liberty and addressing individual capacity. Frailty and disability is the fifth most important factor which affects autonomy in elderly care. When institutions strictly follow their rules and regulations which are based on the schedules, then care staffs have no opportunities to make differences according to the elderly choices and wishes, then it decreases the autonomy of elderly in long term care. (Table 3)

Table 3: Aspects and values of autonomy

Main category	Subcategories	Authentic expression based on data
Aspects	Acting intentionally	Molony (2007),stated it was elucidated that “at-homeness” among older people living in long-term care facilities involved feelings of control and choice.
	Acting with understanding	Elderly residents wanted to make decisions concerning their daily life situations. For example, they wanted to decide about having a siesta, getting fresh air, and about the routines for meals. However, these desires were not fulfilled (Bolmsjö et al. 2006).
	Acting without control	Sometimes the staff and the informal carers suppressed the exercise of older people's choice by making decisions on their behalf, such as when an individual should have her/his bath or what's he/she should wear (Boyle 2004)
	Making own decisions	Opportunities to make choices and decisions in daily life decrease. As a result, the residents' ability for decision making decreases as well (Reinardy 1999; Scott Välimäki, Leni-Kilpi & Dassen 2003; Svidén, Wikström & Hjortensjö-Norberg 2002)

	Freedom to choose	Agich (2003) finds choice to be very important as attention to one's wishes, desires and impulses comprises a significant set of concerns in the ethical analysis of human action.
	Acting without external constraint	Saarnio et al. (2010) finds that there are many variations in the decision-making process concerning the use of physical restraint. According to this study, the decision on the use of physical restraint is normally made by a professional (such as a doctor), nursing staff, or the decision is jointly made by the work community.
	Acknowledge moral values	supporting and empowering residents in making choices regarding engagement and re engagement in valued activities are very important tasks for the staff (Andresen et al. 2009)
	To act as an independent	Independence is about the individual's ability to function independently and make choices—which is called functional independence—or to direct care and negotiate care requirements as in 'executorial' independence. Evidently, all autonomy attributes are not present in independence. Therefore, there is a difference between independence and autonomy(Welford et al. 2010).
	to keep the power of self reliance	Absence of self-reliance makes older people fairly worthless. If one's self-supporting ability is enriched with identity and value, then frailty and physical disability can be compromised (Agich 2003).
	Respecting individual's dignity	According to Fenton and Mitchell (2002: 21) dignity is a 'state of physical, emotional and spiritual comfort, with each individual valued for his or her uniqueness and his or her individuality celebrated'.
	Addressing as an individual human being	Kane (2001) notes, that long-term care providers in all settings pay insufficient attention to learning about the long-term care consumer as a person, a prerequisite to helping the person preserve his or her sense of identity.
	Addressing individual's personality	Health care professionals must respect patients' personalities as well as their personal habits. Moreover, they have to be sensitive to individual patients' perceptions of threatened integrity and the need to develop their own resources (Randers & Mattiasson 2004).
	To prevent serious harm	Severe situations may compel case managers to take paternalistic actions in order to prevent unnecessary risks. Corvol et al. (2013) mentioned some paternalistic action taken by the case managers. Paternalistic action in terms of refusal of care: according to the views of case manager, a refusal to eat may affect the individual's chances of survival.
	Action to minimize risk	In an institutional setting, some routines reflect paternalistic actions on behalf of the staff. Care routines are often structured to minimise risk. Because, in an institutional setting, staffs normally accompany residents while they bath, or they leave their bedroom doors unlocked in case of falling. Such routines, however, could undermine the residents' self-determination. For that reason, institutions often adopt comprehensive policies in this respect (Boyle 2004).
	Acting according to individual's best interest	the long-term care nurses openly expressed their view that care delivery was sometimes determined by schedules rather than by patients' needs. As a consequence, the staff were left with feelings of failure because they had not acted in their patients' best interests (Rees et al. 2009).
	Making differences for frail elderly	Andresen (2009) indicate that even a minimum level of intervention can make a positive difference, both in the short-term and long-term, in people with physical disability and also in older people's perceptions of autonomy.

Values	Acting according to the very best of elderly	having the opportunity to engage in meaningful activities and experiencing satisfaction in life are highly correlated (Legarth 2005)
	Acting according to preferences and desires of elderly	Ordinary and day-to-day decisions and revealed that persons with even moderate cognitive impairment are able to determine their preferences for daily care (Butcher et al. 2001; Menne et al. 2008; Amant et al. 2012).
	Respecting individual (human) rights	If the elderly persons were found incompetent and could not make their own decisions, the family should be trusted to make them with the elder's wishes in mind. Some elders and their families discussed and executed advance directives and care plans to ensure that the elder's wishes were respected (Boisaubin, Chu & Catalano 2007).
	Making self-creation of elderly possible	Dignity' in this format thus includes allowing the elderly person to make decisions on their activities of daily living and other personal and social matters. It is highly important to note, however, that 'dignity' in this case also implies addressing an elderly as a person and to pay proper respect (Boisaubin et al. 2007).
	Individual liberty	Teeri (2006), some of the older persons made the point that they were unable to express their own wishes because everything on the ward was so strictly organized according to set routines that they could do nothing but they had to submit
	Addressing individual's capacity	The paternalistic intervention for restoring or retaining the decision-making capabilities and opportunities of the person concerned should be selected (Shermer 2001).

5.2 Opportunities for exercising autonomy

This study found few opportunities to exercise autonomy in long term care. If elderly can use their skills of self-management abilities it will increase the prospect to practice the autonomy in their later life. Proper opportunities will help the elderly to act as an autonomous person. If the elderly people are treated as an active agent, it will increase more prospect in old age. Addressing and digging out the capability of older people can change the meaning of institutional life. Because capacity can improve their autonomy as the elderly are then engaged in meaningful activities. The author has found that the most important opportunity is changing the view of caregivers towards the vulnerable elderly. Understanding the level of disease can make a big difference for elderly, so the probability of engaging and practicing autonomy will increase. (Table 4)

Table 4: Opportunities

Main category	Subcategories	Authentic expression based the data
Self-management	By utilising their skill in self-management	By utilising their skill in self-management, elderly persons prevent the loss of resources, manage the decline and loss of resources and sustain their well-being. Such self-management abilities are therefore a person's generative capacity to sustain well-being into old age. Thus, the losses in resources constituting frailty is closely linked with the loss of self-management abilities of the elderly (Schuurmans et al. 2004).
	Finding out the active agent from elderly	While younger disabled people have been raised as 'dependent' on others, older disabled people are in general constructed to be the 'objects' of care. In caring relationships, they are almost never recognised as active agents or as equal partners. Older persons, almost as a convention, accept such assumptions instead of opposing or resisting them. Those who live in long-term care settings in particular often find that they are bound to reduce their expectations regarding this as their autonomy declines (Boyle 2008).
	Digging out the capability of autonomy	Older person's mental illness not necessarily means their complete lacking in autonomy. Likewise, it is not always true that cognitive disability makes older persons totally incapable of exercising any autonomy (Boyle 2008).
	By giving proper opportunities	Older people can exercise autonomy if they get proper opportunities. By utilising such opportunities, they should be able to participate in socially meaningful activities and to make significant choices about their lives (Boyle 2004).
	By changing the view of caregiver	If the care staff thinks that the older person suffering from dementia has less probability of having generalised decisional capacity, he/she may also be denied opportunities for acting autonomously even. In such cases, without making any attempt to help older people facilitate the execution of their own decisions, it is very common that the care staff takes decisions on behalf of the older people (Boyle 2004).

6 Conclusion

Due to decreased health condition elderly people are a vulnerable group in the society. For this reason, they are often dependent on care services and entering a long-term care institution is also a difficult challenge for them. Nursing care is not only providing the physical needs to elderly but it also requires an understanding the psychological, sociological, cultural and ethnic needs. Therefore, autonomy in long-term care is a very important aspect in the lives of the elderly people. In this study author tried to investigate autonomy of the elderly in long term care on the basis of the theories of self-determination and autonomy. Two Research questions of this study are: 1. Which factors mostly affect autonomy of the elderly in long term care? And 2. What kind of opportunities the elderly people have to exercise for their autonomy in long term care? Data were collected by using electronic databases, and similar literature were selected to review. For selecting those literature author tried to focus more on elderly autonomy, long term care, dependency, ethics in elderly care settings and so on. Literature were reviewed non- systematically and traditionally to look for those questions and data were analysed by employing the abductive content analysis approach. After analysing the data, this study found five different factors which affects the autonomy of elderly in long term care. Those are- freedom to choose, dependency, dignity, paternalism and frailty / disability. This study also found few opportunities which can help to exercise the autonomy in long term care settings, such as- proper opportunities to use self-management abilities, addressing and digging out the capability of older residents and changing the view of caregivers to the vulnerable elderly. In both cases most of the study mentioned about the strict organizational routines, lack of trained staff, lack of time and different decision-making process. In some studies, elderly expressed their feeling which are directly related with the autonomy.

Based on content analysis, this study found that freedom to choose mostly affects the autonomy in long term elderly care, when opportunities to make own decisions decreases, possibility to act intentionally decreases, decisions are controlled and made by other care staffs and relatives. In a study on Dependence and autonomy in old age, Agich (2003) finds choice to be very important as attention to one's wishes, desires and impulses comprises a significant set of concerns in the ethical analysis of human action. However, this focus makes it difficult to question whether the values implied by one's desires, impulses or wishes are worth having. If someone chooses 'something' on the basis of desire it does not necessarily imply that 'something' is good. Attention to wants or preferences, however, makes the question of the good irrelevant and also restricts the domain of ethics to but one feature among many defining human moral agency. Choice is undeniably important, but not all-important. Attention to the phenomena of choice and decision making has had the unfortunate consequence of rendering otiose other features of autonomy (Agich 2003).

The study of Saarnio et al. (2010) finds that there are many variations in the decision-making process concerning the use of physical restraint. According to this study, the decision on the use of physical restraint is normally made by a professional (such as a doctor), nursing staff, or the decision is jointly

made by the work community. Older patient or a family member can also play an important role in taking such a decision. In addition, the nursing staff discussed the use of restraint with the patient and the decision was made together. In accordance with the results of this study, the patient's family members were considered to have the power to make the decision on the use of restraint alone and the family members frequently discussed the use of restraints with the doctor or the nursing staff.

Decisional capacity of humans is essentially a process, which requires an analysis of an individual's decision-making abilities according to a legal definition. Thus, decisional capacity is ultimately a legal judgment. Yet, in practice and among the older people in particular, such determinations are mostly made by clinicians, attorneys, and other professional groups. These professional groups are clearly outside of legal proceedings (Moye & Marson 2007). Skelton *et al.* (2010) have supported this view by indicating that most interventions for determining capacity/competency are inefficient and highly variable. They have also mentioned that health care practitioners are in general not adequately trained to conduct these types of assessments (Amant *et al.* 2012).

The importance of examining decision making beyond major care decisions like institutionalization of a relative—is highlighted in more-recent studies. These studies have shed light on ordinary and day-to-day decisions and revealed that persons with even moderate cognitive impairment are able to determine their preferences for daily care (Butcher *et al.* 2001; Menne *et al.* 2008; Amant *et al.* 2012). Regarding caring for the older people with dementia, the loss of freedom is more frustrating. The care providers frequently confront older residents' reactions to locked doors. In case the carers have enough time, they can go out and going for walks is given high priority in some departments. Even so, some of the older persons forget that they have been out and often stand at the door waiting. The use of bedrails was also mentioned in connection with physical restraint. Several carers thought it unnecessary to use bedrails, and in some departments this issue is discussed regularly. In other units, such use is routine and apparently never discussed. Caregivers may experience this as an ethical dilemma (Jakobsen 2010).

Although due to dependency, elderly move to the institution but this study found that absence of proper understanding, acknowledging individual's moral values increase the dependency in long term care. So, possibility to act as an independent, keeping the power of self-reliance decreases. Increased dependency found the second factor which affect the autonomy in long term care. When older people are exposed to changes—for instance, moving into a nursing home—they are exposed to several adversities as well. Their physical and psychological deficits (Draper 1996; Johannesen 2004), feelings of being a burden, feelings of loss of control and helplessness increase (Johannesen, Petersen & Avlund 2004; Kane 1995; Rowels 1991). Moreover, their opportunities to make choices and decisions in daily life decrease. As a result, the residents' ability for decision making decreases as well (Reinardy 1999; Scott Välimäki, Leni-Kilpi & Dassen 2003; Svidén, Wikström & Hjortensjö-Norberg 2002). Decision making regarding P-ADL activities in relation to when, how, and so on, are of special

importance for the majority of older people irrespective of their requirements for assistance from staff in performing the activities (Duncan-Myers & Huebner 2000). Kane et al. (1997) notes that not being asked about which activities one finds meaningful to engage in often means that one gives up these activities. This situation may threaten personal identity and indicate near-future physical decline (Andresen 2009).

Bolmsjö et al. (2006) explored everyday ethics in the care of elderly people. According to this study, the residents wanted to be autonomous so that they can decide, influence and have choice in their daily life (self-determination) and also by not being dependent or a trouble to the staff (independence). However, these desires were not fulfilled or met. The interpretation of the notes showed that the residents wanted to make decisions concerning their daily life situations. For example, they wanted to decide about having a siesta, getting fresh air, and about the routines for meals. However, these desires were not fulfilled because of a number of factors (Bolmsjö et al. 2006). They further confirm that the residents were afraid of being a trouble to or disturbing the staff with their needs and desires. They wanted to be as independent as possible and do whatever they were able to do so that they can manage on their own (Bolmsjö et al. 2006).

Whether to acknowledge dependency as a normal, but truly essential, social condition is not clearly specified in the literature. In our private lives, dependency creates a bondage among people to tie them together. For instance, for a child depending on adults for guidance it very necessary, otherwise the child's growth will be deeply damaged. He/she may feel profoundly insecure and may not develop as a normal human being who is unable to learn. Again, Sennett (2003) notes that avoiding the sick, old and weaker people who needed our help, may leave the adults in a situation where they may not make friendship with others. However, dependency publicly gives a shameful impression. Like the concept of 'care', dependency is an ideological and a social concept (Fraser & Gordon 1994). Fraser and Gordon (1994) identified four types of dependency: economic dependency, socio-legal dependency, political dependency and moral or psychological dependency. Similarly, Walker (1982) differentiated several types, or causes, of dependency in old age: life-cycle dependency, physical and psychological dependency, political dependency, economic and financial dependency and structural dependency. Also, the definition proposed by Gibson (1998) includes economic, political, legal, psychological and emotional dependencies. It is possible to distinguish each of these dependencies from dependency which arises from age-related ill health or frailty. The latter applications of the concept are particularly relevant to gerontological research, which has produced an extensive literature on the measurement of dependency (Harrefors, Sävenstedt & Axelsson 2009).

During the period of aging, dependence starts as one's capability of self-reliance declines gradually. In a way, it is somewhat diminishment of one's individual worth. As commonly experienced, absence of self-reliance makes older people fairly worthless. If one's self-supporting ability is enriched with identity and value, then frailty and physical disability can be compromised. The actual idea of active

life expectancy as an empirical measure of population health is basically based on this point. In accordance with this measure, several activities and abilities—such as, bathing, dressing, eating and mobility—are correlated with a sense of functional well-being. The loss of these functional abilities signifies loss of independence (Agich 2003).

Thus, by sustaining the web of connection, care activity signifies seeing and responding to need so that no one is left alone (Gilligan 1984). Gilligan (1984) adds moral perspectives into care activities and recognised an idiosyncratic set of moral principles linked to ‘care’. This type of ‘ethic of care’ is mostly seen among women and is the outcome of a process of moral growth. On the contrary, the rule-based, impersonal justice is often linked with male maturity. Others attempted to signify the widely used concept of ‘dependency’ as strongly emotional, but essentially a contested concept, especially in terms of elder care. But though ‘care’ is a positive concept, dependency is rather cold and its implications are nearly entirely negative (Fine & Glendinning 2005).

However, dilemmas exist between dependency and the bioethical definition of autonomy as independence which is well discussed in Collopy (1995). He emphasised that rethinking in this regard is required. In the nursing home setting, we must consider dependency and autonomy as intertwined facets of one’s life and state of being (Mette Andresen 2009).

In their concept analysis of self-determination among older people Ekelund et al. (2014) highlighted on the dilemmas between autonomy and dependence. In the article, case X wants to shower on Tuesday and Friday, but as he is dependent on home care services and health care organizations simultaneously, it was not possible for him to do so. To dress his sores after shower, he must shower when it is suitable for both home care services and health care organizations. In this case, he is able and has the knowledge of making a decision, but he cannot control the entire process and is not free to exercise his own choice as he is dependent on others. But due to his legal and ethical rights, he gets the help needed to shower, even if not exactly when he wishes. Thus, X agrees to the timing, but it is not in line with what he wants (Ekelund et al. 2014).

‘Autonomy’ is frequently confused with ‘independence’ though these terms are not the same. Often, they are also mixed up with concepts like free will and equal relationships. Davies et al. (1997) underlines that independence concerns to individual’s level of physical functioning and his/her ability to perform activities of daily living without taking any assistance. Thus, independence is about the individual’s ability to function independently and make choices—which is called functional independence—or to direct care and negotiate care requirements as in ‘executorial’ independence. Evidently, all autonomy attributes are not present in independence. Therefore, there is a difference between independence and autonomy. Additionally, we must not confuse independence and autonomy with ‘capacity’ although ‘capacity’ is a vital element in autonomy. According to O’Shea et al. (2008), capacity is basically evaluated on an issue-specific and time-specific basis. Therefore,

having capacity for one decision may not necessarily imply the requisite capacity, might be potentially different, for another decision. The older person in residential care, however, should experience 'the functional approach' (Welford et al. 2010).

Dignity is found as a third factor which affect the autonomy of elderly in long term care. The insufficient attention of Care staff to address the elderly individual as a human being and properly addressed individual's personality affect the dignity and same time it also affect the autonomy of elderly care. Dignity can be of two types: 'absolute' dignity and 'relative' dignity. According to Beyleveld and Brownsword (2001), absolute dignity is all about respecting every person as an individual having freedom and responsibility. Absolute dignity can never be destroyed or taken away, nor even won or lost. At the most, it can be respected or violated. On the contrary, relative dignity, principally a factor of the culture in which individuals belong to, is also determined by individual's education and social background and social network (Mairis 1994, Moody 1998). Relative dignity may disappear with the vanishing of cultural conditions. Thus, importantly, as Shotton and Seedhouse (1998) note, health care professionals should be aware of the ethical and non-ethical values so that each patient feels that his/her dignity is fully respected (Randers & Mattiasson 2004).

According to Fenton and Mitchell (2002: 21) dignity is a 'state of physical, emotional and spiritual comfort, with each individual valued for his or her uniqueness and his or her individuality celebrated'. The concept of 'dignity', however, is often related to or confused with 'autonomy'. In the concept analysis of Welford et al. (2010), such clarification of what autonomy is not further clarified.

Among family members, however, the term 'dignity' is greatly related with a person's mind, body and spirit. In that case, 'dignity' is mainly considered as showing respect to a person's above states. While we consider a family, therefore, the long-term care setting seems insignificant given that the elderly persons were appropriately respected, honoured and cared for. 'Dignity' in this format thus includes allowing the elderly person to make decisions on their activities of daily living and other personal and social matters. It is highly important to note, however, that 'dignity' in this case also implies addressing an elderly as a person and to pay proper respect (Boisaubin et al. 2007).

Family is a vital factor for preserving dignity of the elderly and accordingly, nurses generally aims at making decisions with the family. As Boisaubin et al. (2007) notes, respondents of their study on the perceptions of long-term care, autonomy and dignity also agreed that decision of an elderly person would take precedent if there is any disagreement between family members. In cases where financing is a big concern in a family feud, court-appointed guardians and power of attorney are utilized formally. They emphasize that external agents should keep out of the family's decision making as far as possible (Boisaubin et al. 2007). By dignity, the it was meant that "the individual gets to live as normal a life as they did at home." Respect implied not only an acknowledgement of the respondents' attainment of age, but it also included privacy and accepting personal decisions regarding their desire

for treatment. All respondents of the abovementioned study believed that respecting the residents' needs and desires was a continual struggle. Some long-term care facilities were able to better negotiate the differences than others (Boisaubin et al. 2007).

In the aforesaid study, the term 'dignity' was perceived to be a very important issue by all interviewed. Most of them equated 'dignity' with 'respect', but various other definitions were also offered. Many of the elderly people had a tendency to redefine the concept 'dignity' as 'humane'—attentive care provided towards themselves by others whether they are in a home or long-term care facility. One of the respondents emphasized the importance of maintaining at the end of life. Others attempted to define the concepts of privacy, autonomy and the ability to care for one's self, including control over one's own mental and physical functions. In order to provide a practical example, administrators of the long-term care facilities emphasized how they struggle almost daily of balancing personal needs and desires of the elderly (often equated with 'respect') and the needs of running an institution with rules and limited resources (Boisaubin et al. 2007).

Andersson (1996) studied perceived autonomy and activity choices among physically disabled older people. This study found that the body with its intimate spheres is very private to any individual. Therefore, health care professionals have to understand, and remain sensitive to, any violation of the boundaries of the personal sphere. This personal sphere, however, can differ from person to person (Randers & Mattiasson 2004). Besides, as Andersson (1996) notes, health care professionals must respect patients' personalities as well as their personal habits. Moreover, they have to be sensitive to individual patients' perceptions of threatened integrity and the need to develop their own resources (Randers & Mattiasson 2004). Again, the study of Andersson (1996) indicates that respecting a patient's personality and individual habits is extremely important. In this manner, patients feel seen and respected, and are given the opportunity to develop and maintain their own resources rather than just being recipients of care (Randers & Mattiasson 2004).

Both residents and staff wanted to be respected and this fact is clearly evident from interpretation of the texts. However, the respect for each other was either insufficient or lacking between staff and residents, amongst residents, and amongst staff. Residents desired attention (*i.e.*, seen and heard) and to get help as per requirement. It was also evident from the texts that residents wanted to be noticed in numerous circumstances. They were afraid of being forgotten, abandoned and not seen. It was also described that individual residents had feelings of being outsiders in the group of residents and staff. These residents interpreted not being noticed as a form of punishment for being too troublesome.

'Dignity' denotes the perception that one's dignity is respected. However, there is a related but different notion, which is obviously important, that each person is treated with dignity irrespective of whether he or she can distinguish indignities. 'Dignity' is basically a requirement in nursing home regulations. This concept is possibly less relevant to the more cognitively impaired, since

considerable self-awareness is needed to experience a sense of indignity. However, as an anecdote though, Kane (2001) found that some residents with substantial dementia resonated to the concept of dignity. One such person answered a general question about her dignity that it was the problem of a long-term care and care staff treat them as though they are children (Kane 2001).

'Individuality' is referred to as the consumer's sense of being known as a person and being able to continuously experience and express his or her identity. 'Individuality' also means to have desired continuity with the past. From a psychological point of view, Tobin (1991) emphasizes that the hardest task for many residents is to maintain their own identity against all the forces that erode their sense of self. Research has shown, as Kane (2001) notes, that long-term care providers in all settings pay insufficient attention to learning about the long-term care consumer as a person, a prerequisite to helping the person preserve his or her sense of identity.

Paternalism which is most common in long term elderly care, found the fourth important factor which affect the autonomy. Though some institutions practice paternalistic behaviour to prevent harm and minimize risk due to refusal of care and refusal to eat, but this practice is also a debatable issue. It is related with how care staff are respecting individual liberty and addressing individual capacity.

This section provides a definition of paternalism and then discusses three strategies that can be used to justify paternalistic interference. The ethical theory conceptualizes the problem of 'paternalism' in terms of two disagreeing aspects: first, respect for the right to self-governance and second, respect for or promotion of well-being. Examples of paternalism are as follows: the need for wearing seat belts while driving, refraining a child from going out without his/her coat on, or preventing someone from crossing an unsafe bridge. In the medical domain, corresponding examples can take the following forms: tying a patient to his/her bed so that he/she may not fall, giving patients an unwanted medication without their consent, and not informing a patient of a fatal diagnosis that he/she may not be able to tackle.

If not always, 'paternalism' is sometimes justified. It is justified as long as it prevents serious harm to the person concerned and if his/her actual wishes are burdened or involuntary. This may so happen because of the following reasons. The person may be either unduly pressured, or his/her capability of decision-making is substantially diminished, or he/she lacks relevant information. Paternalistic interventions can be temporary as well. It is in that case justified only if establishing whether a person's choices are independent is necessary.

In this regard, there are three points to consider. First, values are very important to follow because the paternalistic action should be in accordance with the values held by the person concerned. Second, the paternalistic intervention for restoring or retaining the decision-making capabilities and opportunities of the person concerned should be selected. Third, the selected intervention should provide a net benefit for the subject and be as effective as possible (Shermer 2001).

In their study on ethical issues in the introduction of case management for elderly people Corvol et al. (2013) mentioned some paternalistic action taken by the case managers. Paternalistic action in terms of refusal of care: according to the views of case manager, a refusal to eat may affect the individual's chances of survival. Hospitalisation was then recommended without the individual's consent. Paternalistic action in terms of a risk of malnutrition: several case managers reported that not eating enough—possibly because of a loss of functional autonomy—could somehow lead them opt for home carers who could handle both shopping and cooking. Paternalistic action in terms of a risk of abuse of weakness involving the need for legal protection: All case managers in this study agreed that legal protection measures could be undertaken without the individual's consent if the individual was informed (Corvol et al. 2013).

In an institutional setting, some routines reflect paternalistic actions on behalf of the staff. Care routines are often structured to minimise risk. Because, in an institutional setting, staffs normally accompany residents while they bath, or they leave their bedroom doors unlocked in case of falling. Such routines, however, could undermine the residents' self-determination. For that reason, institutions often adopt comprehensive policies in this respect. Such policies do not always allow for an individual's level of ability or willingness to accept a degree of risk (Boyle 2004).

Health care was historically provided in a paternalistic manner. However, many changes have taken place in society over the years. Such changes are now challenging the future of healthcare provision. Health care needs to be more empowering and negotiated between healthcare professionals and their clients (McCormack 2001). Autonomous action require a considerable degree of understanding and freedom. Therefore, as Burkhardt and Nathaniel (2002) note, in order to keep a balance between personal autonomy and restrictive health care institutions, some fundamental elements are necessary. They are as follows: (i) respect, (ii) the ability to direct and determine personal goals, (iii) the capacity to be involved in a decision-making process, and (iv) the freedom to act on any choices made (Welford et al. 2010).

Severe situations may compel case managers to take paternalistic actions in order to prevent unnecessary risks. The study on ethical issues conducted by Corvol et al. (2013) mentioned these. In such situations, the case managers primarily aim at defending the individual's choice against family or institutional partners. They also intend to prioritise respect for autonomy, not in all situations though. They identified the following three factors where the case managers were not to respect an individual's will. First, the seriousness of the risk incurred by the individual; second, the severity of cognitive impairment; third, the individual's determination (Corvol et al. 2013).

Corvol et al. (2013) noticed different experiences regarding case managers' sharing of collected information with other stakeholders. While some case managers emphasised that sharing of information can facilitate the organisation of care, several other case managers were reluctant to even reveal the collected personal data. There should be a justifiable balance between information

gathering and sharing. On the one hand, enough care is required for information collection and sharing to maintain the principle of beneficence. On the other hand, appropriate respect is needed so that data privacy is not undermined that might harm the individual (Corvol et al. 2013).

A number of studies develop the concept of routine-centred care in contrast to patient-centred care focusing on the long-term care of older people. The study by Palviainen et al. (2003), for instance, explored the use of power by nurses in both acute and long-term care. In this study, 59% of long-term care nurses stated that they adhered strictly to the bathing list; 16% required patients to go to the toilet according to the unit's schedule; and about 33% required patients to go to bed at the same time each evening. These findings confirm that long-term care nurses sometimes exercised power over their patients when they considered that routines should be preferred to individual needs. On the contrary, however, Rees et al. (2009) mentioned another study in which the long-term care nurses openly expressed their view that care delivery was sometimes determined by schedules rather than by patients' needs. As a consequence, the staff were left with feelings of failure because they had not acted in their patients' best interests (Rees et al. 2009).

The quantitative study of Wagner and Tabak (1998) identified family members of the patients to be the second most common source of ethical dilemmas after doctors. These responses were given by about 72.5% of the nurses in the study. Normally, the needs of the patients and those of their relatives do not always match and ethical conflicts arose from this gap. For example, there can be situations where a patient may decide to stop eating, while a relative wanted to feed the patient against his/her will, or situations where relatives sought extreme forms of treatment despite patients' suffering or their own wishes. In this connection, examples are given in relation to end-of-life decision making for older people. They were of families who did not accept that their relative was dying and wanted to continue invasive treatment. Some families might not even wish important information to be disclosed to their relative. Another study reported ethical issues arising from family members disagreeing not only with the patient but also with health professionals regarding appropriate treatment, and with each other. Rees et al. (2009) highlights that the highest number of ethical issues reported by health professionals is related to family members.

In a study conducted by Teeri (2006), some of the older persons made the point that they were unable to express their own wishes because everything on the ward was so strictly organized according to set routines that they could do nothing but they had to submit. One patients reported: "you have to be content here and not to go against anyone; they won't listen". This clearly describes older people's feelings on lack of respect.

To cite an example, Ekelund et al. (2014) mentions the case of Y. He/she lives alone in a house, already had a stroke and is now confined to a wheelchair. So, case Y does not have the knowledge or ability to decide for himself/herself, nor do others allow him to act and decide for himself in line

with his own free choice. He/she can still do some daily activities for living, but everything takes longer. The homecare service helps Y to shower two times per week. He manages most parts of the showering, but Y has no liberty to decide when to shower or the order in which Y washes his/her body. Therefore, as the case reveals, the homecare service people do not consider that persons confined to a wheelchair are capable of making their own decisions (Ekelund et al. 2014).

Frailty and disability is found the fifth factor in this study, which affects the autonomy in elderly care. When institutions strictly follow their rules and regulations which are based on the schedules, then care staff have no opportunities to make differences according to the elderly choices and wishes, then it decreases the autonomy of elderly in long term care. Frailty is defined to be a loss of resources in several domains of functioning, such as mobility loss or a specific disease. This type of loss ultimately leads to a declining reserve capacity of the elderly for dealing with stressors. Most medical interventions focus on these lost resources, but they focus mainly on single resource. Focusing only on one resource, however, may not be enough as elderly persons often confront with the loss of several resources concurrently. As a result, they become frailer in a general sense (Schuurmans et al. 2004).

Chronological age results in a significant decline in self-management abilities. But, frailty relates more strongly to such decline in self-management capacities. By utilising their skill in self-management, elderly persons prevent the loss of resources, manage the decline and loss of resources and sustain their well-being. Such self-management abilities are therefore a person's generative capacity to sustain well-being into old age. Thus, the losses in resources constituting frailty is closely linked with the loss of self-management abilities of the elderly (Schuurmans et al. 2004).

There are several ways in which people with disabilities get dependent on others. Able-bodied persons may not always understand all of them. It is true that some people with disabilities are particularly prone to the vulnerabilities of inevitable dependency. It is equally true that there are some attitudinal issues as well. People with disabilities are somehow constructed as dependent on others, though there is no need of doing so. In this connection, Kittay (2006) notes that having access to wheelchairs and living in a place where buildings are accessible may reduce the dependency needs for people with mobility impairments to a large extent.

Kittay (2006) notes that although people with disabilities can very well undertake caring for dependents, they are often thought to be disqualified from such responsibilities. This happens primarily because of prejudice, ignorance or lack of social supports. People are withdrawn from taking responsibilities they in fact can assume. Thus, they are actually prevented from flourishing only because of some unnecessary social factors, though their inherent nature of the impairment was not the cause as such. Ethically, care giving is a central mode of human ethical interaction. Relationships formed through care truly establishes one's very identity. Therefore, it is quite justified

that appropriate policies are required to meet caregiving needs and desires of people with disabilities (Kittay, 2006).

The results of the study of Andresen (2009) indicate that even a minimum level of intervention can make a positive difference, both in the short-term and long-term, in people with physical disability and also in older people's perceptions of autonomy. For the elderly who are still relatively young, physical health and capacity play a vital role in perceiving autonomy. Whereas for the real old, perceptions of autonomy with feelings of control and having freedom of choice are highly significant. However, age-related distinctions may not be that important in case of institutionalization of care that has an impact on the perception of autonomy (Andresen 2009).

The situations get worse and turn into most difficult ones when care providers are to handle the older people with dementia. Their ability for intellectual and deep thought is significantly reduced to varying degrees, which is one of the major consequences of this illness. Such inability affects both themselves and the surroundings they live in, which essentially affect their capacity of making sensible and considered choices of action as well (Jakobsen 2010).

This study also found few opportunities to exercise autonomy in long term care. If elderly can use their skills of self-management abilities it will increase the prospect to practice the autonomy in later life. Proper opportunities will help the elderly to act as an autonomous person. However, not all older people can easily exercise their autonomy. With the help of necessary material and emotional resources older people have the ability to become autonomous and they should be provided with these resources (Doyal & Gough 1991). Older people can exercise autonomy if they get proper opportunities. By utilising such opportunities, they should be able to participate in socially meaningful activities and to make significant choices about their lives. Although opportunities for exercising autonomy can often be very limited for older people living in different types of care settings. Research studies support this view. For example, the quality of life study in Belfast in particular demonstrate a gloomy picture. The study found that only 52% of residents living in institutions and 30% of clients living in private households experienced a relatively high level of autonomy (Boyle 2004). Institutionalisation generally undermines the autonomy of the disabled people. However, for personal assistance dependency on family members or community services can restrict personal autonomy. Likewise, older people living at home and receiving informal care services may also have numerous constraints on their autonomy. However, for long-term care the older people frequently lack control over daily life. As the Belfast study confirms, this is true irrespective of whether the older people are in an institution-based care setting or they are in any privately-owned household-based care (Boyle 2004).

According to the results of the Belfast study, in terms of executing the decisions of the older people with less executorial autonomy, their decisional autonomy is greatly constrained by being dependent

on staff and informal carers. In comparison with other older people, older disabled people with more severe impairments have in particular high probability of facing restrictions on their decisional autonomy (Boyle 2005). From this point of view, it is highly likely that the decisional autonomy of the older people may be ignored since the older people do not have sufficient ability to execute their own decisions (Boyle 2005). Much of these greatly depend on the assumptions of the care staff, especially what he/she thinks of the decisional capacity level of the older people with dementia. For example, if the care staff thinks that the older person suffering from dementia has less probability of having generalised decisional capacity, he/she may also be denied opportunities for acting autonomously even. In such cases, without making any attempt to help older people facilitate the execution of their own decisions, it is very common that the care staff takes decisions on behalf of the older people (Boyle 2004).

Doyal and Gough (1991) note that mental health is generally a prerequisite of autonomy. However, ill mental health can also be an outcome of impaired autonomy. If the decisional autonomy of an older person is restrained, it might contribute to develop depression to an older person. The Belfast quality of life study found that just over half (52%) of the domiciliary care sample had probable depression, compared with over one-quarter (28%) of the residents in residential and nursing homes. Again, ill mental health was more common in the privately-owned household sample, where the level of perceived autonomy was much lower. Therefore, the resultant effects of constraints on autonomy, for instance depression, are evidently not only limited to the institutions, but such depressive effects may be more commonly seen in private households (Boyle 2005).

Randers and Mattiasson (2004) examined the relationship between autonomy and integrity in interactions between patients and individual health care workers in real-life care situations. They note that the ethically difficult question is to determine when patients are unable to make decisions. Collopy (1988) finds that by giving patients opportunities to delegate certain activities and decisions to health care professionals, 'delegated autonomy' is exercised. It is of a shared nature and, as such, has to be seen as a valid form of autonomy (Randers & Mattiasson 2004).

If elderly is treated as an active agent, it will increase more prospect in old age. Addressing and digging out the capability of older people can change the meaning of institutional life. Because Capacity can improve the autonomy in a way when elderly is engaged in meaningful activities. The study of Boyle (2004) highlights the opportunities to exercise autonomy. "High quality care" essentially means the care recipient's choice of the carer and of the care locus (especially the choice to remain at home) as well as the satisfaction of emotional needs (Daly 2002). However, for choice to contribute meaningfully to the QOL of older people, the concepts need to be widened to incorporate choice and control over aspects of everyday life within the long-term care settings. Hardy et al. (1999) examined choice over services provided by the assessment and care management process. Again, however, it is argued that facilitating the older person's choice is not just about the

organisation of services, although aspects such as when to go to bed are fundamental. In some institutions, the exercise of choice is constrained by the availability of staff/informal carers. Sometimes the staff and the informal carers suppressed the exercise of older people's choice by making decisions on their behalf, such as when an individual should have her/his bath or what's he/she should wear (Boyle 2004).

Moreover, having the opportunity to engage in meaningful activities and experiencing satisfaction in life are highly correlated (Legarth 2005). Therefore, as Shawler, Rowels and High (2001) note, supporting and empowering residents in making choices regarding engagement and reengagement in valued activities are very important tasks for the staff (Andresen et al. 2009). Recently, Andresen et al. (2009) conducted a meta-synthesis on physically frail and cognitively intact older people in nursing homes. Their study showed that older people were able to express themselves clearly about the importance of making choices and exerting control in daily life. Choices related to the daily routines regarding when, how and with whom to perform them and choices related to activities in agreement with their intrinsic interests and values were of special importance. In a study by Molony (2007), it was elucidated that "at-homeness" among older people living in long-term care facilities involved feelings of control and choice.

Mental health represents both the emotional and cognitive capacity to exercise autonomy (Doyal & Gough 1991). As they argue, autonomy requires at least a certain level of rationality which is usually unavailable in disabled—emotionally or mentally—persons. To be specific, as they further argue, in this sense seriously and permanently ill older people have either lost or never possessed sufficient level of autonomy for successful and intentional social interaction. So, mental illness (e.g., depression) and cognitive impairment (resulting from, for instance, dementia) negatively affect older person's capacity for autonomy. However, as the authors have accepted, older person's mental illness not necessarily means their complete lacking in autonomy. Likewise, it is not always true that cognitive disability makes older persons totally incapable of exercising any autonomy. Importantly, however, the authors also implicitly endorsed the role of mental and physical health as a basic human need, since mental health is necessary for the exercise of autonomy (Boyle 2008).

Old age is commonly meant for dependency. Again, dependency, which is related to impairment, is frequently equated with vulnerability, inactiveness and loss of autonomy (Morris 2005). While younger disabled people have been raised as 'dependent' on others, older disabled people are in general constructed to be the 'objects' of care. In caring relationships, they are almost never recognised as active agents or as equal partners. Older persons, almost as a convention, accept such assumptions instead of opposing or resisting them. Those who live in long-term care settings in particular often find that they are bound to reduce their expectations regarding this as their autonomy declines (Boyle 2008).

Quite on the contrary to what they have expected originally, older people generally get restricted autonomy. But they try to adjust with it. Abundant research findings are available to demonstrate that when the older people's autonomy is often constrained, for instance, by the staff or the rules of a care home. In those cases, the elderly people frequently discover that their choices are unimportant. In addition, since they do not enjoy freedom of choice very much, thus their choices become irrelevant. Comparatively less-dependent older people, however, are free to do what they want to. In other cases, though older people are nearly bound to be content and integrate with the restrictions imposed. To others, who do not fit in these two groups, the constraints are confining and frustrating (Boyle 2008).

Older people's dependency on others can be explained with the help of the above-mentioned Hellström and Sarvimäki (2007) study. In a sheltered housing, commonly older people are dependent on other people for decision making. Dependency increases as the older person's need for care increases. The Hellström and Sarvimäki (2007) study finds that relatives, temporary (paid) volunteers and trainees were important resources for fulfilling the older people's wishes, such as going outdoors. Relatives were also important in pushing through demands of the older people. The informants, mostly dependent on the staff, believed that the staff lacked training and the trainees were not adequately qualified. The staff schedules and routines strongly directed life in the sheltered housing facility and lack of time was considered a problem. As the study finds, it was not possible to ask for more help because the staff did not have enough time. Longer period of time was spent waiting for the staff to come. According to this study, the factor creating a loss of self-determination was unavailability of time for discussion with the staff. Also, the residents did not have the opportunity to express their needs. The number of staff was insufficient. Older people think that it would be nice to talk to the staff sometimes, if they could sit down for a moment (Hellström & Sarvimäki 2007).

The above said study mentioned that the participants had various ideas on important things in their everyday lives that they could control. Many reports on their concerns for the time schedules they had. Several participants wanted to get up earlier in the morning; some wanted to have different food, but they had not been able to make a difference. One woman had to share a room, against her will. Many respondents thought that cleaning was not performed too frequently, once in every two or three weeks, based on when the resident had moved into the building. The accommodation of the person who came most recently was cleaned once in every three weeks. The respondents were unhappy about not being able to decide about cleaning. Some thought the place was untidy and they disliked it. Respondents argued that many times they liked to have schedule in a little different way, but it is difficult, it has to go according to the rules. One respondent reported that he would like to have a little coffee in the morning. According to the study, the older persons were not entirely self-evident for going to toilet as needed. Unlike now, some reported that they used to go to the toilet when they wanted. Most of them, however, thought that going to the toilet worked well. Some

respondents suggested for going a couple of hours before if someone wants to go to the toilet. They say you just went, so that should be enough (Helström & Sarvimäki 2007).

Author has found the most important opportunity is, changing the view of caregivers to the vulnerable elderly. Understanding the level of disease can make a big difference for elderly, the probability of engaging and practicing autonomy will increase.

The study of Boisaubin, Chu and Catalano (2007) explored the views and perceptions of long-term care residents, family members and health care providers. They found that if the elderly persons were found incompetent and could not make their own decisions, the family should be trusted to make them with the elder's wishes in mind. Some elders and their families discussed and executed advance directives and care plans to ensure that the elder's wishes were respected (Boisaubin, Chu & Catalano 2007).

Values of the health care professionals and their beliefs about and attitudes towards older adult patients are extremely important for care. These greatly affect their views on and approaches towards the patients in their care. In this respect, the frailty and dependency of the older adults are important factors to consider. Also, how the lack of equality between health care professionals and patients are overcome is very important. These factors to a great extent affect the ethical quality of care (Randers & Mattiasson 2004).

Doyal and Gough (1991) note that mental health is generally a prerequisite of autonomy. However, ill mental health can also be an outcome of impaired autonomy. If the decisional autonomy of an older person is restrained, it might contribute to develop depression to an older person. The Belfast quality of life study found that just over half (52%) of the domiciliary care sample had probable depression, compared with over one-quarter (28%) of the residents in residential and nursing homes. Again, ill mental health was more common in the privately-owned household sample, where the level of perceived autonomy was much lower. Therefore, the resultant effects of constraints on autonomy, for instance depression, are evidently not only limited to the institutions, but such depressive effects may be more commonly seen in private households (Boyle 2005).

Frustration and distress are two other effects of constraints on the autonomy imposed on older people suffering from dementia. When people with frustration and distress cannot entirely express their feelings, they may show agitation as an alternative means of communication. Among all of the common causes, conflict between residents of care setting or with nursing staff and invasion of personal space are the most important and common cause of such agitation. Lack in autonomy and loss of control over a situation are the major underlying reasons for agitation. Therefore, nursing home staff must promote autonomy among people suffering from dementia. This is supported by, for instance, Sloane et al. (1998). This study finds no agitated behaviour in some units. This study also

highlights that the independent correlates of low levels of agitation included minimal use of physical restraint. However, some studies support using appropriate methods of restraint to be legitimately used to prevent harm to the individual or others, though such restraints may restrict the older person's liberty. However, care staff should be cautious that restraints are appropriate, and not excessive (Guidance from the Royal College of Nursing (2004). Askham et al. (2007) suggest types of the care to be given to older persons suffering dementia but living at home with family members or friends. They identified that occasionally older persons "had their freedom of movement constrained or were ignored or denied the right to speak, such that the care given was somewhat even abusive." But also, evidences are there that they were otherwise supported to maintain their identities.

However, the behaviour of older people suffering from dementia, mostly confirmed pathological tests, is commonly believed to be resulting from a disease. But, it is rarely understood that this behaviour is actually a valid response to an inadequate social environment. Thus, the behaviour of older persons with dementia becomes abnormal and symptomatic. This is similar to the experiences of people with learning difficulties. Expressions of emotions (such as, anger or grief) have been defined as a 'challenging behaviour' for people with learning difficulties. They are thought to be the result of a 'mental impairment'. Doyal and Gough (1991) specified cognitive capacity as a prerequisite to being autonomous. However, the suppression of autonomy notably inhibits the use of extant cognitive capacity among people with dementia. In other words, restraining the decisional autonomy of older people with dementia can contribute to their cognitive disability, rather than considering such impairment solely as a manifestation of dementia itself. Consequently, older people in long-term care need to have their autonomy facilitated to promote their well-being (Boyle 2008).

According to the results of the Belfast study, in terms of executing the decisions of the older people with less executional autonomy, their decisional autonomy is greatly constrained by being dependent on staff and informal carers. In comparison with other older people, older disabled people with more severe impairments have in particular high probability of facing restrictions on their decisional autonomy (Boyle 2005). From this point of view, it is highly likely that the decisional autonomy of the older people may be ignored since the older people do not have sufficient ability to execute their own decisions (Boyle 2005). Much of these greatly depend on the assumptions of the care staff, especially what he/she thinks of the decisional capacity level of the older people with dementia. For example, if the care staff thinks that the older person suffering from dementia has less probability of having generalised decisional capacity, he/she may also be denied opportunities for acting autonomously even. In such cases, without making any attempt to help older people facilitate the execution of their own decisions, it is very common that that the care staff takes decisions on behalf of the older people (Boyle 2004).

As elsewhere around the world, physical restraints have been applied for decades as a common part of care of older people In Finland (Paasivaara 2002). A recent study on care of older people in Finnish

institutions found that most (88%) of work units had used physical restraint in their work. In Finland, the care of patients with intellectual or developmental disabilities or mental health problems is highly regulated. But, the use of restraint in the care of older people is not regulated by legislation in Finland (Saarnio *et al.* 2007). Saarnio *et al.* (2010) note that the majority of work units in care of older people had not written policies concerning the use of physical restraint. As a consequence of inadequate legislation and written policies, nurses are confronted with tough decisions relating to the use of physical restraint in their day-to-day work. As a consequence, it is very much likely that they do not see the use of physical restraint, which is already an established practice, as a limitation of older persons' autonomy (Saarnio *et al.* 2010).

In the study of Bolmsjö *et al.* (2006), it is shown that the residents tried to attract the staff's attention and wanted to obtain help for their basic physical needs. But they had to wait for a long time before receiving this help. This may happen due to a number of reasons. For instance, there might be some conflict between different demands on behalf of the staff. There may be conflicts between residents' desires and other tasks, residents' desires and loyalty to colleagues, or helping an individual resident and providing the same help to all residents. Sometimes the staff also justified their lack of help as an ambition to preserve residents' independence.

7 Discussion

Based on literature review, we know that autonomy is a choice where an informed consent is rational but few factors affect their autonomy in long term care. In this study, autonomy in long term care is affected by outside control while Boyle (2004) states that sometimes the staff and the informal carers suppress the exercise of older people's choice by making decisions on their behalf, such as when an individual should have her/his bath or what's he/she should wear. In terms of using physical restraints, this study also found that the decision-making process made by the other person, for example, Saarnio *et al.* (2010) finds that there are many variations in the decision-making process concerning the use of physical restraint. According to this study, the decision on the use of physical restraint is normally made by a professional (such as a doctor), nursing staff, or the decision is jointly made by the work community. As autonomy supports the view that individual have the freedom to choose, Rosello (2002) and Agich (2003) find choice to be very important as attention to one's wishes, desires and impulses comprises a significant set of concerns in the ethical analysis of human action. but this study found that in long term care, opportunities to make choices and decisions in daily life decrease. As a result, the residents' ability for decision making decreases as well (Reinardy 1999; Scott Välimäki, Leni-Kilpi & Dassen 2003; Svidén, Wikström & Hjortensjö-Norberg 2002). So, making own decisions is not always possible by the elderly. Andresen *et al.* (2009) states that supporting and empowering residents in making choices regarding engagement and re-engagement in valued activities are very important tasks for the staff by acknowledging moral values of elderly, then they

can act with understanding. But in long term care, this study found, elderly residents wanted to make decisions concerning their daily life situations. For example, they wanted to decide about having a siesta, getting fresh air, and about the routines for meals. However, these desires were not fulfilled (Bolmsjö et al. 2006). Literature says that autonomous action is in terms of normal choosers who act intentionally. Again, in Molony (2007) it was elucidated that “at-homeness” among older people living in long-term care facilities involved feelings of control and choice. Due to increased disability and dependency, act as an independent is not always possible in frail elderly. Independence is about the individual’s ability to function independently and make choices—which is called functional independence—or to direct care and negotiate care requirements as in ‘executorial’ independence. Evidently, all autonomy attributes are not present in independence. Therefore, there is a difference between independence and autonomy (Welford et al. 2010). In terms of keeping the power of self-reliance. Agich (2003) mentioned that Absence of self-reliance makes older people fairly worthless. If one’s self-supporting ability is enriched with identity and value, then frailty and physical disability can be compromised.

Elderly should be addressed as an individual human being, but this study found that long-term care providers in all settings pay insufficient attention to learning about the long-term care consumer as a person. This is a prerequisite to helping the person preserve his or her sense of identity (Kane 2001), and also it should be respected by respecting their dignity where dignity is a ‘state of physical, emotional and spiritual comfort, with each individual valued for his or her uniqueness and his or her individuality celebrated’ (Fenton and Mitchell 2002). Therefore, respecting dignity could be improved by addressing individual’s personality as earlier studies found, e.g., health care professionals must respect patients’ personalities as well as their personal habits. Moreover, they have to be sensitive to individual patients’ perceptions of threatened integrity and the need to develop their own resources (Randers & Mattiasson 2004). In an institutional setting, some routines reflect paternalistic actions on behalf of the staff. Care routines are often structured to minimise risk. Because, in an institutional setting, staffs normally accompany residents while they bath, or they leave their bedroom doors unlocked in case of falling. Such routines, however, could undermine the residents’ self-determination. For that reason, institutions often adopt comprehensive policies in this respect (Boyle 2004). To prevent serious harm, Severe situations may compel case managers to take paternalistic actions in order to prevent unnecessary risks. Corvol et al. (2013) mentioned some paternalistic action taken by the case managers. Paternalistic action in terms of refusal of care, according to the views of case manager, is a refusal to eat may affect the individual’s chances of survival. Whereas, autonomy allows people to want something as they wish and to act knowingly and willingly. Autonomy is the independence of doing what one wants to do consistent with the social and political circumstances and according to one's strengths. In that sense, autonomy consists of human’s capability of choosing a way of thinking (Rossello 2002). Sometimes institutional rules and regulations, restricts the autonomy of elderly in long term care as Rees et al. (2009) mentioned. The long-term care nurses openly expressed their views that care delivery was sometimes determined by schedules rather than by patients’ needs. But making differences can change the quality of care in

long term settings as Andresen (2009) indicate that even a minimum level of intervention can make a positive difference, both in the short-term and long-term in people with physical disability and also in older people's perceptions of autonomy. By respecting individual rights, providing the very best of elderly according to the preferences and desires, Legarth (2005) mentioned that having the opportunity to engage in meaningful activities and experiencing satisfaction in life are highly correlated. Addressing individual's capacity is also important to protect their autonomy.

Though old age is related with impairments and disability, but older people can exercise autonomy if they get proper opportunities. By utilising such opportunities, they should be able to participate in socially meaningful activities and to make significant choices about their lives (Boyle 2004). Health care staff and practitioners have the kind of training to dig out the capability of elderly and find out the active agent from elderly, because, older person's mental illness not necessarily means their complete lacking in autonomy. Likewise, it is not always true that cognitive disability makes older persons totally incapable of exercising any autonomy (Boyle 2008). In this case, Schuurmans et al. (2004) mentioned that by utilising their skill in self-management, elderly persons prevent the loss of resources, manage the decline and loss of resources and sustain their well-being. Such self-management abilities are therefore a person's generative capacity to sustain well-being into old age. On the other hand, the exercise of autonomy also depends on the view of care personnel, if the care staff thinks that the older person suffering from dementia who has less probability of having generalised decisional capacity, he/she may also be denied opportunities for acting autonomously (Boyle 2004).

Further study is needed to explore the capacity and ability of the elderly with severe mental impairments. To improve the wellbeing of the elderly, we need to know more about the policy and regulations of different care settings as well. Because, in most of the cases elderly people have mentioned about the lack of staff, lack of time and strict organisational routines. So, organisations need to be careful of those things. Decision making process is very important in dementia care. Do elderly people have the opportunity to join the process and how frequently the decision which has been made by the process can be assessed. It is very important to evaluate whether the decision is still appropriate for all the members. In severe dementia care, it is obvious to support the executional autonomy of elderly. The practice of decisional autonomy and executional autonomy is important in long term care. Understanding the level of disease will help to understand the practice of elderly autonomy. Care staff's view on dependency, frailty and disability can change the lifestyle of elderly in long term care.

References

- Agich, G. J. 2003. Dependence and Autonomy in Old Age. An Ethical framework for long-term care. Cambridge university press.
- Amant, O., Ward-Griffin, C., Deforge, R. T., Oudshoorn, A., McWilliam, C., Forbes, D., Kloseck, M., & Hall, J. 2012. Making Care Decisions in Home-Based dementia Care: Why context Matters. Canadian Journal on Ageing, 31(4): 423-434.
- Andresen, M., Runge, U., Hoff, M., & Puggaard, L. 2009. Perceived Autonomy and Activity Choices Among Physically Disabled Older People in Nursing Home Settings: A Randomized Trial. Journal of Aging and Health. 21(8) 1133-1158.
- Andersson, M. 1996. Integritet som begrepp och princip. En studie av ett a°rdetiskt ideal i utveckling [Integrity As A Concept And A Principle. A Study of A Nursing Ethical Ideal in Progress]. Åbo Akademi, Åbo (in Swedish).
- Askham, J., Briggs, K., Norman, I., & Redfern, S. 2007. "Care at home for people with dementia: As in a total institution?" Ageing and Society, 27: 3-24.
- Beauchamp, T. L., & Childress, J. F. 2001. Principles of Biomedical Ethics. Oxford University Press: New York.
- Beyleveld, D. & Brownsword, R. 2001. Human Dignity in Bioethics and Biolaw. Oxford University Press, Oxford
- Beauchamp, T. L. 2001. Principles of biomedical ethics. 5th ed.. New York: Oxford University Press.
- Bolmsjo, I. A., Sandman, L. & Andersson, E. 2006 . EVERYDAY ETHICS IN THE CARE OF ELDERLY PEOPLE. Nursing Ethics 13 (3).
- Boisaubin, E.V., Chu, A. & Catalano, J. M. 2007, Perceptions of Long-Term Care, Autonomy, and Dignity, by Residents, Family and Care-Givers: The Houston Experience. Journal of Medicine and Philosophy, 32:447-464.
- Boyle, G. 2004. "Facilitating choice and control for older people in long-term care." Health and Social Care in the Community, 12(3): 212-20.
- Boyle, G. 2005. "The role of autonomy in explaining mental ill-health and depression among older people in long-term care settings." Ageing and Society, 25: 731-48.
- Boyle, G. 2008. "Autonomy in long-term care: a need, a right or a luxury?" Disability and Society, 23(4): 299-310.
- Butcher, H. K., Holkup, P. A., Park, M. & Mass, M. 2001. Thematic analysis of the experience of making a decision to place a family member with Alzheimer's disease in a special care unit. Research in Nursing and health, 24: 470-480.

Corvol, A., Moutel, G., Gagnon, D., Nugue, M., Saint-Jean, O. & Somme, D. 2013. Ethical issues in the introduction of case management for elderly people. *Nursing Ethics* 20(1): 83-95.

Collopy, B. 1988. Autonomy in long time care: some crucial distinctions. *The Gerontologist* 28 (Suppl.), 10-17.

Collopy, B.J. 1995. Power, paternalism and the ambiguities of autonomy. In *Enhancing autonomy in long-term care, concepts and strategies*, ed. L.M. Gamroth, J. Semradek, and E.M. Tornquist, 3-14. New York: Springer.

Cavanagh, S. 1997. Content analysis: concepts, methods and applications. *Nurse Researcher* 4, 5-16.

Daly, M. 2002. Care as a good for social policy. *Journal of Social Policy*.31(2), 251-270.

Davies, S. Ellis, L. & Laker, S. 1997. Promoting autonomy and independence for older people within nursing practice: a literature review. *Journal of Advanced Nursing* 26, 408-417.

Deci, E. L. & Ryan, R. M. 2000. The "What" and "Why" of Goal Pursuits: Human Needs and the Self Determination of Behavior. *Psychological Inquiry*, 11: 227-268.

Deci, E. L. & Ryan, R. M., 2008. Self-Determination Theory and the Role of Basic Psychological Needs in Personality and the Organization of Behavior. John, Oliver P. (Ed); Draper, P. 1996. Compromise, massive encouragement and forcing: a discussion of mechanisms used to limit the choices available to older adults in hospital. *Journal of Clinical Nursing*, 5, 325-331.

Duncan-Myers, A. M., & Huebner, R. A. 2000. Relationship between choice and quality of life among residents in long-term care facilities. *American Journal of Occupational Therapy*, 54, 504-508.

Doyal, L., & Gough I. 1991. *A Theory of Human Need*. London: Macmillan.

Downe-Wamboldt, B. 1992. Content analysis: method, applications and issues. *Health Care for Women International* 13, 313-321.

Eklund, C., Dahlin-Ivanoff, S. & Eklund, K. 2014. Self-determination and older people - A concept analysis. *Scandinavian Journal of Occupational Therapy*. 21:116-124.

Elander, G. & Hermeren, G. 1989. Autonomy and paternalistic behaviour in care. *Scandinavian Journal of Caring Science*; 3:153-9.

Faden, R.R. & Beauchamp, T.L. 1986. *A history and theory of informed consent*. New York: Oxford University Press.

Fenton, E. & Mitchell, T. 2002. Growing old with dignity: a concept analysis. *Nursing Older People* 14, 19-21.

Fine, M., Glendinning, C. 2005. Dependence, independence or inter-dependence? Revisiting the concepts of "care" and "dependency". *Ageing and society* 25:601-621.

- Fraser, N. & Gordon, L. 1994. A genealogy of dependency: tracing a keyword of the US welfare state. *Signs*, 19, 2, 309-34.
- Gilligan, C. 1984. In *a Different Voice: Psychological Theory and Women's Development*. Harvard University Press, Cambridge, Massachusetts.
- Grimes, A.L., McCullough, L.B., Kunik, M.E., Molinari, V. & Workman, R.H. 2000. Informed consent and neuroanatomic correlates of intentionality and voluntariness among psychiatric patients. *Psychiatric Services* ;51(12):1561-1567. [PubMed: 11097654]
- Harrefors, C., Saïvenstedt, S. & Axelsson, K., 2009. Elderly people's perceptions of how they want to be cared for: an interview study with healthy elderly couples in Northern Sweden. *Scandinavian Journal of Caring Science*; 23; 353-360
- Hardy, B., Young, R. & Wistow, G. 1999. Dimensions of choice in the assessment and care management process: the views of older people, carers and care managers. *Health and Social Care in the Community* 7(6), 483 - 491.
- Hellström, U. W., & Sarvimäki, A. 2007. "Experiences of self-determination by older persons living in sheltered housing," *Nursing Ethics*, 14(3): 413-424.
- Jakobsen, R., & Sørli, V. 2010. Dignity of older people in a nursing home: Narratives of care providers. *Nursing Ethics*, 17(3): 289-300.
- Johannesen, A. 2004. A study of old people who in spite of frailty are coping successfully with changes in their daily life. Unpublished master's thesis, Queen Margaret University College, Edinburgh, Scotland.
- Johannesen, A., Petersen, J., & Avlund, K. 2004. Satisfaction in everyday life for frail 85-year-old adults: A Danish population study. *Scandinavian Journal of Occupational Therapy*, 11, 3-11.
- Kane, R. A. 1995. Autonomy and regulation in long-term care: Odd couple, an ambiguous relationship. In L. Gamroth (Ed.), *Enhancing autonomy in long-term care* (pp. 68-86). New York: Springer.
- Kane, R. A., Caplan, A. L., Urv-Wong, E. K., Freeman, I. C., Aroskar, M. A., & Finch, M. 1997. Everyday matters in lives of nursing home residents: Wish for and perception of choice and control. *Journal of the American Geriatric Society*, 45, 1086-1093.
- Kane, R. A. 2001. Long-Term Care and a Good Quality of Life: Bringing Them Closer Together. *The Gerontologist*. Vol. 41, No. 3, 293-304
- Kasila, K., Poskiparta, M., Karhila, P. & Kettunen, T. 2003 Patients' readiness for dietary change at the beginning of counselling: a transtheoretical model-based assessment.
- Kittay, E.F., Jennings, B. & Wasunna, A.A. 2005. Dependency, Difference and the Global Ethic of Long Term Care. *The Journal of Political Philosophy*. 13(4): 443-469.

Kloezen, S. & Fitten, L. J. 1988. Steinberg A. Assessment of treatment decision-making capacity in a medically ill patient. *J Am Geriatr Soc* ; 36:1055-8.

Krippendorff, K. 1980. *Content Analysis: An Introduction to its Methodology*. Sage Publications, Newbury Park.

Legarth, K. H. 2005. The most important activity and the reasons for that experience reported by a Danish population at age 75 years. *British Journal of Occupational Therapy*, 68, 501-508.

Mairis, E.D. 1994. Concept clarification in professional practice:dignity. *Journal of Advanced Nursing* 19, 947-995.

McCormack, B. 2001. *Negotiating Partnerships with Older People: a Person-Centred Approach*. Ashgate, UK.

Miller, B. 1995. Autonomy. In: Reich, WT., editor. *Encyclopaedia of bioethics*. 2nd ed.. New York: Macmillan; p. 215-220.

Morris, J. 2005. Citizenship and disabled people. Disability Rights Commission. Available at: <http://disability-studies.leeds.ac.uk/files/library/morris-Citizenship-and-disabled-people.pdf> (Accessed on December 20, 2016).

Molony, S. L. 2007. Psychometric testing of an instrument to measure the experience of home. *Reserach in Nursing & Health*, 30, 518-530.

Moody, H.R. 1998. Why dignity in old age matters. *Journal of Gerontological Social Work* 29, 111-127.

Moye, J., & Marson, D. C. 2007. Assessment of decision making capacity in older adults: An emerging area of practice and research. *The journals of Gerontology. Series B, Psychological sciences and social sciences*, 62 (1): 3-11.

Menne, H. L., Tucke, S. S., Whitlatch, C. J., & Feinberg, L. F. 2008. Decision-making involvement scale for individuals with dementia and Family caregivers. *American Journal of Alzheimer's Disease and Other Dementias*, 23(1): 23-29.

Naik, A.D., Pickens, S., Burnett, J., Lai, J.M.& Dyer, C.B., 2006 Assessing capacity in the setting of self-neglect: Development of a novel screening tool for decision-making capacity. *Journal of Elder Abuse and Neglect*. 8(4):79-92. [PubMed: 17972661]

National Institute on Ageing 2016. *Living Longer*. Available at: <https://www.nia.nih.gov/research/publication/global-health-and-aging/living-longer>. Accessed: 14 December 2016.

O'Shea, E. Murphy, K. Larkin, P. Payne, S. Froggatt, K. Casey, D. Ni'Le'ime A' & Keys, M. 2008. *National Council on Ageing and Older People. End of Life Care for Older People in Acute and Long-stay Care Settings in Ireland*. National Council on Ageing and Older People, Dublin.

- Paasivaara, L. 2002. Multi-Level Analysis of the Evolution of Finnish Geriatric Nursing From 1930s Till the 2000s. Acta Universitatis Ouluensis D707, Oulu University Press, Oulu, Finland. (Abstract in English).
- Palviainen, P., Hietala, M., Routasalo, P., Suominen, T., & Hulpi, M. 2003. Do nurses exercise power in basic care situations? *Nursing Ethics*, 10: 269-80.
- Petticrew, M. & Roberts, H. 2006. *Systematic reviews in the Social Sciences: A Practical Guide*. Oxford: Blackwell.
- Randers, I. & Mattiasson, A., 2004. Autonomy and integrity: upholding older adult patients' dignity. *Journal of Advanced Nursing*, 45(1), 63-71.
- Rynning, E. 1994. Consent to medical care and treatment: A legal study. PhD thesis, Uppsala University, Uppsala.
- Rees, J., King, L., & Schmitz, K. 2009. "Nurses' Perceptions of Ethical Issues in the Care of Older People." *Nursing Ethics* 16(4): 436-452.
- Reinardy, J. R. 1999. Autonomy, choice and decision-making: How nursing home social workers view their role. *Social Work in Health Care*, 29(3), 59-77.
- Reichertz, J. 2013. Induction, Deduction, Abduction in: *The SAGE handbook of qualitative data analysis*.
- Robins, R. W. & Lawrence. A. (Ed). *Handbook of personality: Theory and research*, 3rd ed., pp. 654-678). New York, NY, US: Guilford Press, xv, 862 pp.
- Rossello, F. T. 2002. The Limits of the Autonomy Principle. *Philosophical Considerations* in Kemp, P. and Rendtoref, J. D. (eds.) *Basic Ethical Principles in European Bioethics and Biolaw* vol. II, Copenhagen/Barcelona, Center for Ethics and Law, pp. 217-236.
- Royall, D.R. Lauterbach, E.C. Cummings, J.L. Reeve, A. Rummans, T.A. & Kaufer, D.I. 2002. Executive control function: a review of its promise and challenges for clinical research. A report from the Committee on Research of the American Neuropsychiatric Association. *Journal Neuropsychiatry and Clinical Neuroscience*. 14(4):377-405.
- Saarnio, R., & Isola, A. 2010. "Nursing staff perceptions of the use of physical restraint in institutional care of older people in Finland." *Journal of Clinical Nursing*, 19: 3197-3207.
- Saarnio, R. Isola, A. & Backman, K. 2007. Physical restraint in institutional elderly care: forms of restraint, frequency of use and reasons for use. *Journal of Social Medicine*, 44: 109-119.
- Sandelowski, M. 1995. Qualitative analysis: what it is and how to begin? *Research in Nursing & Health* 18, 371-375.

- Schuurmans, H., Steverink, N., Lindenberg, S., Frieswijk, N., & Slates, J. P. J. 2004. Old or Frail: What tells us more? *Journal of gerontology: Medical Sciences*, 59A(9): 962-965.
- Sennett, R. 2003. *Respect: The Formation of Character in a World of Inequality*. Allen Lane, London.
- Scott, P.A. Välimäki, M. Leini-Kilpi, H. & Dassen, T. 2003. Autonomy, privacy and informed consent: Elderly care perspective. *British Journal of Nursing*, 12, 158-168.
- Svidén, G. Wikström, B. M. & Hjortensjö-Norberg, M. 2002. Elderly persons' reflections on relocating to living at sheltered housing. *Scandinavian Journal of Occupational Therapy*, 9, 10-16.
- Shawler, C. Rowels, G. D. & High, D. M. 2001. Analysis of key decision making incidents in the life of a nursing home resident. *The Gerontologist*, 41, 612-622.
- Shotton, L. & Seedhouse, D. 1998. Practical dignity in caring. *Nursing Ethics* 5, 246-255.
- Skelton, F. Kunik, M. E. Regev, T. & Naik, A. D. 2010. Determining if an older adult can make and execute decisions to live safely at home: A capacity assessment and intervention model. *Archives in Gerontology and Geriatrics*, 50(3): 300-305.
- Schermer, M. H. N. 2001. The different faces of autonomy. A study on patient autonomy in ethical theory and hospital practice.
- Suhonen, R. Stolt, M. Launis, V. & Leino-kilpi, H. 2010. "Research on ethics in nursing care for older people: A literature review." *Nursing Ethics*, 17(3): 337-352.
- Tavory, I. Timmermans, S. 2014. *Abductive analysis: Theorizing qualitative research*. The university of Chicago press, Ltd., London
- Tobin, S. S. 1991. *Personhood in advanced old age*. New York: Springer.
- Teeri, S. Leino-kilpi, H. & välimäki, M. 2006. Long-Term nursing care of elderly people: Identifying ethically problematic experiences among patients, relatives and Nurses in Finland. *Nursing Ethics*. Vol. 13. Issue 2
- Walker, A. 1982. Dependency and old age. *Social Policy and Administration*, 16, 115-35.
- Welford, C., Murphy, K., Wallace, M., & Casey, D. 2009. CARE FOR OLDER PEOPLE-A concept analysis of autonomy for older people in residential care. *Journal of clinical Nursing*. 19:1226-1235.
- Workman, R.H. McCullough, L.B. Molinari, V. Kunik, M.E. Orengo, C. & Khalsa, D.K 2000. Clinical and ethical implications of impaired executive control functions for patient autonomy. *Psychiatric Services*. 51(3):359-363. [PubMed: 10686244]