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Perception of Nurses on the Establishment, and their Willingness to Work in Assisted Living Facilities in Ghana

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Abstract: Aim: This study explored the perception of Ghanaian nurses on the establishment and their willingness to work in assisted living facilities. Methods The study used a mixed-methods approach in which qualitative data was collected first before the quantitative data. Data was collected through Focused Group Discussions (FGDs) and questionnaires from 248 respondents with age ranging from 20 to 58 years from October 2016 to January 2017 with 8 missing from the quantitative data. Four pertinent questions were asked in both set of data. Sampling was convenient and purposive from 4 different health facilities in the metropolis. Data from the FGDs were digitally recorded and transcribed verbatim. Quantitative data was entered in SPSS version 23 and cleaned. Both sets of data were coded and analyzed. Results The nurses appreciated the increase in the number of the aged in their communities; they think community members prepare towards their ageing by using their children as security, and the idea of assisted living was enthusiastically supported by 66% of the population, but with the proviso that it would need to be ran by a private entrepreneur, then they would be willing to work in such a facility. Discussion: The nurses also think that families are now becoming more nuclear; that is why caring for the aged has become a problem, thus creating a need for assisted living facilities.
Keywords: *Aged, Assisted living/Care, Care, Nurse, Willingness to work.*
Abbreviations: *FGD-Focused Group Discussions, NHHAS- National Home Health Aide Survey, NP- Nurse practitioners, LEAP- Livelihood Empowerment against Poverty and SWOT- Strengths Weaknesses Opportunities Threats.*

1. Introduction

Caring for older people is a humbling experience, regarded as unselfish and loving assistance given to another [1]. It is about responsibility and watching over the other and can be carried out by a lay person [2]. Assumptions are that nursing practice focuses on what matters for nurses caring for the elderly, thus listening attentively to what the elderly say about themselves and their lives, gives cues on what is meaningful for them and how their quality of life, peace of mind, body and soul is Bernick [3]. The challenges of caring for older individuals can be a scary task for health care providers because it requires multi-specialty expertise with the focus of meeting the

individual's psychological, cultural, spirituality and physiologic needs [4]. Policies in Western societies have been geared towards enhancing facilities as a home domain for residents through regulation of sheltered accommodation and nursing care facilities for older persons to increase their autonomy [5]. From a caring perspective, there is an emphasis on the staff and the organization respecting the older person's integrity and personal boundaries, both relational and corporeal [6]. Well-being in older peoples' everyday life is dependent on respect for their integrity and dignity which is very important [7].

2. Background

2.1. Overview of Assisted Living Facilities

Demand for home-based care is rapidly increasing as baby boomers are ageing and advanced medical technologies are extending the life expectancy of disabled and chronic patients, with an estimate that by 2050, 27million people will need some type of long-term care [8]. The National Home Health Aide Survey (NHHAS) also estimated that almost 1.46million older people were receiving care in 2007 and 7.2 million had received care and were discharged in 2000 [9]. And over 14,000 agencies were in the business of recruiting and training caregivers for serving clients. Assisted living is any residential setting not licensed as a nursing home but provides or arranges personal care and routine nursing in a homelike residential setting [10]. It is regulated according to its state or region, which also reflects different philosophies about who should be served in these residential long-term care settings and the relationship envisaged between assisted living and nursing homes [11]. These facilities are living arrangements that provide personal care and health services for people who may need assistance with activities of daily living but wish to live independently. The level of care provided is not as extensive as that which may be provided in nursing homes [12]. Assisting living is not an alternative to a nursing home, but an intermediate level of long-term care. One facility may look like a modern high-rise apartment building; another might look like a quiet suburban town home community. Others may resemble a resort hotel or a country club, but there are some generalizations [13].

The homelike nature of the settings also varies a great deal among and within state, with some assisted living settings providing single-occupancy apartments and others providing shared accommodations in board-and-care settings with two or more persons per room [14]. Apartment-style assisted living, by design, offers privacy and the opportunity for autonomy. It also exposes residents to

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risks of everyday life associated with cooking and bathing and tends to afford staff less opportunity for protective surveillance. Whether the service is provided by internal staff, outside home care agencies, or a combination of these, assisted living tends to be more lightly staffed than nursing homes [14].

2.2. Care in an Assisted Living Facility

Nurse Practitioners (NPs) provide direct patient care and it involves cognitive assessment, reviews, ordering and /or reviewing tests and medication, and liaising with family members [15]. Referrals by NPs include referrals to geriatricians, to general practitioners, to allied health professionals (e.g. physiotherapists, dieticians), and to social service (e.g. home care and dementia support program) [16]. The role of a registered nurse in the residential aged care facility is multifaceted and includes miscellaneous forms of caring, managing the individual impact of ageing, the opportunities of clients and their respective regarding care needs [17].

They are required to provide leadership and guidance in care directives, which includes training learning and development of other subordinate staff and team members, and assisting clients make informed decisions, particularly in relation to treatment choice, palliative pathways and end-of-life issues [18]. It is also noted that RNs are the clinical leaders in aged care in effective management of staff retention within their service [19]. Among the various staff types in a geriatric center are contract staff and aids including certified nursing assistants, home health aides, personal care aides or assistants, and medication technicians or aides.

Social workers include licensed social workers, graduates with a bachelor or master degree in social work in adult day service centers and residential care communities, and medical social workers [20]. The normal working hours per day in nursing homes and residential care settings for adult day services, home health agencies and hospices have been reported as averaging 8 hours per day in three 24-hours section shifts [21], with a worker-to-caregiver ratio of 3:26 [22]. Nurse practitioners spend considerably more time with the elderly than do general practitioners attached to these facilities. They are more accessible, able to initiate more timely care, visit elderly people in their homes and thereby increase access to care for those who are not mobile or not able to drive themselves for services [23].

NPs undertake more comprehensive assessments of older persons than registered nurses; this means that there is better quality of clinical information to be used by the broader healthcare team in ordering diagnostic tests or initiating appropriate medicines, and timelier treatment schedule for acute facility and can circumvent complications of the condition [23]. From an economic perspective, nurse practitioners in Australian aged care save dollars for government funders through their timely and accurate care interventions.

Economic efficiencies were gained through reductions in: unnecessary transfers to acute health facilities, ambulance costs, hospital bed days, and thus hospital cost [24].

2.3. Health Care System

In Ghana, most health care is provided by the government and is largely administered by the Ministry of Health and Ghana Health Services. The healthcare system has five levels of providers: health posts or level A, health centers and clinics-level B, district hospitals Level C, regional hospitals or level D and tertiary hospitals Level E. Currently, the country has 170 of health facilities operated by the Ghana Health Service; 71 by missions; 281 by private facilities; and 8 by the Ashanti quasi-government [25].

Apart from allocations from tax revenue, the Ghanaian health system is financed by direct out-of-pocket (OOP) payments (accounting for nearly half of all health care expenditure) and health insurance (composing of premiums and government payroll deductions). These user fees and direct payments disproportionately affect the poor and the aged. The aged support their health care through personal income, family support and National Health Insurance Scheme (NHIS). Family support, Livelihood Empowerment against Poverty (LEAP) grants and rents on property owned by these aged are the major sources of funds available to them [26].

2.4. Traditional Caring System in Ghana

The total population of Ghanaians is 31.1million and that for the aged is 1.301,000 constituting 4.6% of the total population. The population of male to female aged is 598,000 to 703,000. Majority of the aged are household heads or spouse of heads in the households in which they reside [27]. The aged living accommodation is complex. They live in a dwelling either owned by them, a household member or rented; but majority are resident in houses owned by a relative. Ownership of houses is low among the aged, considering that the aged are expected to have their own houses to command some respect. Traditionally, aged care is the responsibility of family members and care is provided within the extended family home, but in recent times, elderly care is now being provided by the government or charitable organizations. The reasons for this change include decreasing family size, increasing life expectancy, increasing number of the aged to the decreasing number of the dependent family members, the geographical dispersion of these family members, the tendency for women to be educated and work outside the home [28].

Many elderly people are gradually losing functioning ability and require additional assistance in their homes. Family members or any person providing care for the aged are considered to be caregivers, however, in the Ghanaian formal system caregivers are healthcare providers who are health professionals such as doctors, nurses who are not nurse practitioners but registered nurses, and midwives with scientific knowledge about the diagnosis or treatment of diseases afflicting people and who had worked in the medical field for at least a year [26]. Ghana has no organization for the aged apart from facilities for community-based rehabilitation so the study explored how various stakeholders including nurses would appreciate the establishment and their willingness to work in assisted living facilities before lobbying government to establish them.

Aim: The aim of the study is to explore Ghanaian nurses' perception on assisted living facilities and their willingness to work in these facilities.

3. Materials and Methods

3.1. Design and Setting

A sequential mixed-method study design was employed for the study. This study is a sub-study of a bigger study that developed a model for the care of the aged in the Cape Coast metropolitan area; so therefore, a report from one of the populations used for the

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bigger study. The researcher sought to elaborate on or expand on the findings of one method with another. The study began with a qualitative investigation for exploratory purposes, followed by a quantitative approach with a large sample so that there could be generalization of results to the population [29]. Therefore, a focused group discussion was used to collect data followed by administration of questionnaires. The questionnaire was designed to answer questions that were missed during the qualitative phase. The study was carried out in the Cape Coast Metropolitan Assembly, one of the 17 districts of the Central Region of south Ghana. This metropolis is further divided into 25 sub-metros for effective administrative purposes. Of the 25 sub-metros, 10 were randomly selected using SPSS version 20 software, and an adjoining community was used to test study instruments. These 10 sub-metros were further classified into three different zones: urban (elite residential communities), peri-urban (either urban or rural, but densely populated) and rural (lacking almost all social amenities).

Subsequently, the zones were demarcated as zones A, B, and C. All the government health facilities in the Central region are in the metropolis. Four health facilities were used for the study, considering one teaching hospital, a metropolitan hospital, a quasi-hospital, and a psychiatric hospital, in which all the categories of nurses are located. Looking at the individual strength of these health facilities, a proportional-to-size approach was used in allocating estimated sampling populations from which participants were recruited. It was concluded by the principal investigator (PI) and research team that the Regional Hospital, which was a referral center for all major and complex cases, would be allocated 40% of the estimated sample size, because of the number of nurses present there.

Table 1.
Research sites and activities.

Site	Zones	Status of facility/Staff strength	Activity/Number of respondents
Site 1	A	Regional Hospital-Level C category of hospital/348	Questionnaires-96
Site 2			
Site 3		Metropolitan Hospital level B category of hospital/185 FGD-20--FM	Questionnaires-48
Site 4			
Site 5	B	*	*
Site 6			
Site 7	C	Quasi-Hospital-level B category of hospital/170	Questionnaires-24
Site 8		FGD-10-destroyed	
Site 9		Psychiatric hospital Level C category hospital/228	Questionnaires-72
Site 10		FGD – 20 ---FP	

Note: No institution is located in this zone –no activity was carried out there.

This was followed by 30% for the psychiatric hospital which served the middle belt of the country and one of the three government psychiatric hospitals in Ghana. The district hospital and the University hospital, which is a quasi-hospital, followed with 20% and 10% respectively.

3.2. Sampling and Data Collection Techniques

A total of 248 nurses was originally proposed for the study so 248 questionnaires were sent out, but only 240 questionnaires were collected because these were the respondents willing to give the needed time and information due to their busy schedules. Forty participants were recruited to participate in the three focus group discussions (FGDs). Two groups were made up of 15 participants each and the 3rd groups were 10 registered nurses. The inclusion criterion was all categories and ranks of nurses, but excluding midwives on the grounds that these were in a specialized branch of nursing that did not have much contact with the aged. All the groups had a combination of all the category of registered nurses and the discussions ended at a point where saturation was reached; a point the PI and the assistant were not getting any new information. Hence, PI in the selection of the study participants did not consider the ranks of the population in the facilities. The nurses were selected using convenience sampling technique because of their availability at the study site. These methods were appropriate because the nurses were very busy with clients and their residents are scattered in the communities. Getting them after work was very difficult so the FDGs were held during their duty shift. The PI and the research assistant collected all the qualitative data. An unsaturated interview guide was used to conduct discussions.

The four main questions for all the groups were as follows; (a) what was the welfare of the aged in regard to activities of daily living on a scale of 0 to 10? (b) How did the aged prepare for their current situation? (c) Should the government establish assisted living facility? (d) Would nurses be willing to accept responsibility in caring for the aged in an assisted living facility? The questionnaire included both structured and semi-structured questions, which were divided into five sections: Section A -personal information; Section B-preparedness of the aged for their ageing; Section C-current care practices looking at activities of daily living; Section D-care that needed to be added to what the aged currently received: Section E-willingness of nurses to accept responsibility in caring for the aged in an assisted living facility.

An introductory letter and a gatekeeper from University of KwaZulu-Natal and the Dodowa Research center was sent to the individual facility's research officers and one field worker each was assigned to assist in data collection. Appointments were scheduled for commencement of data collection for both the focus group discussions and the questionnaires. The facility research officers (FROs) sensitized the nurses in preparation for the focus group discussions and a period of seven days was allocated to organized participants for the discussions. After each discussion, a week was scheduled for those who had attended the discussion to meet with other nurses for responding to the questionnaires so that key informants sent the message to other parts of the facility through grapevine communication about the impending data collection.

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The age range of target population was 20 to 58 years. Strengths Weaknesses Opportunities Threats (SWOT) analysis was used to explain the reason for the research to participants which was mainly on what assisted living facility was and how it is managed since there was none in Ghana. So, the SWOT analysis was on assisted living, types and how it was funded. Five field workers and a research assistant were recruited, based on their knowledge and experience of the topic under study and were given three days of training.

Data collection began in October 2016 and ended in January 2017. Although three FGDs were scheduled, difficulties due to nurses' workloads and distance of the from the facilities could not allow for 3 but 2 FGDs, the 3rd discussion was marred with a lot of background noise from a construction work near the place the discussion was held so that discussion was discarded followed by the collection of the quantitative data. Each of the discussions lasted between 40 minutes and one hour. A total of 240 questionnaires were completely answered out of 248 giving a 97% of questionnaire return rate.

A quota system was used where each health facility was given a number of questionnaires to answer through their research officers with the help of the field workers considering the total population of the facility. Any nurse met at the data collection point (convenient and purposive sampling) was included and taken through the questionnaire. Those who were busy were given a day or two to complete and return the form, with follow-ups from field workers. Participants and respondents were assured of confidentially and anonymity before each procedure began by giving them consent forms to sign, and those who were not ready to be part of the study were given the opportunity to withdraw.

3.3. Data Management and Analysis

The recorded FGDs were transcribed verbatim from the native language into English by the PI and the trained research assistant. The transcripts were checked for accuracy and quality and cleaned for anonymity by the PI. When no discrepancies were identified, the files were coded for analysis. The methods of analysis were interpretive descriptive analysis to gain insight into the perception and willingness of nurses to work in caring for the aged in an assisted living facility [30]. In an initial step, the content of the data files was read to identify the major distinctive themes that provided meaningful constructs and illuminated the concept under study.

Three key elements of interpretative descriptive analysis were followed: detection (which involved identification), assigning the substantive content and displaying dimensions of the topics under study. Six major themes and three sub-themes emerged: trends of ageing, preparedness of the aged for ageing, government plans for the aged, caring and caregivers, assisted care (sub-themes: cultural ideologies, inception and funding), and acceptance of responsibility. Quantitative data was analysed alongside and presented in tabular presentation at the end of the themes that needed augmentation.

3.4. Strengths and Limitations of this study

- Convenient purposive sampling procedures were followed making data collection a bit easier for the research team.
- Arrangement for the FGDs to fit nurses' work schedules, workloads and distance from home was difficult, and although PI and assistant conducted three FGDs, two came out well but the third was disrupted by noise from construction work in a last-minute change of venue, affecting the data.
- The nurses also complained about the number of pages to be read, and there were a lot of distractions from their clients.
- Problems also arose in trying to coordinate focus group meetings with changes of shift and we also recognized researcher impact on the study participants.

4. Results

4.1. Participant Characteristics

The nurses showed mixed feelings about the intent of the study, but were willing to give researchers the needed information. Of the 40 participants recruited for the 3 FGDs, all had successfully completed their basic nursing education; six had also completed their baccalaureate, and four had master degrees. They were all Christians and married. Three were females and 37 males; ages ranged from 25 to 44 years. Some had children while others did not. The demographic characteristics from data collected from the questionnaire blended with the characteristics of those in the FGDs.

Data collected from the participants was first edited, coded and analyzed using Statistical Package for Social Sciences (SPSS) version 20. The editing process was done to check inconsistencies from participants, whether all items had been responded to and took care of outliers in the data by removing them from the data set. Data was analysed and presented in a descriptive presentation of frequencies and cross tabulation. About 48.8% of eligible respondents in the quantitative study were in the 20-29 years age group, and just 2.9% were in the 50-59 years age group. Majority of those who had time for questionnaires were female, single and Christians. More than half (53.8%) had a diploma qualification as their highest level of educational attainment, and they were either general or psychiatry nurses with the rank of staff nurse.

4.2. Trends in Ageing

Ageing and death is inevitable, when participants were asked if they had noticed that the population of the aged had increased in their communities, they thought it was due to the aged being pushed into the hospitals because of festive occasions and because community members did not want the aged to be in their way. Some knew about this trend in research reports form dissemination of results to the hospital; others had not because they spent most of their time in the hospitals and scarcely interacted with the community. Another participant agreed that the aged were increasing in number possible because of public health strategies or health promotion activities. All the participants echoed the point made by one contributor that, Yes…we have seen that because the aged are being pushed into the hospitals on festive occasions.

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Table 2.
Quantitative data on demographic characteristics of nurses.

Variables		N = (240)	100%
Aged (Years)	20-29	117	48.8
	30-39	100	41.7
	40-49	16	6.7
	50-59	7	2.9
Sex	Male	89	37.1
	Female	151	62.9
Marital status	Single/Never married	124	51.7
	Married	115	47.9
	Divorced/separated	1	0.4
			90
Religious affiliation	Christian	216	7.1
	Islam	17	2.5
	Traditional religion	6	0.4
	No religion	1	
Level of education	Certificate	42	17.5
	Diploma	129	53.8
	Degree	61	25.4
	Masters	7	2.9
	PhD	1	0.5
Category of nursing	Health assistant	36	15
	Community health	11	4.6
	General nurse	136	56.7
	Psychiatry nurse	57	23.8
Ranks of nurses	Deputy director of nursing service (DDNS)	3	1.2
	Principal nursing officer (PNO)	6	2.5
	Senior nursing officer (SNO)	25	10.5
	Nursing officer (NO)	14	5.8
	Senior staff nurses (SSN)	42	17.5
	Staff nurse (SN)	114	47.5
	Community health nurse (CHO)	33	13.8
	Enrolled nurse (EN)	3	1.2

Source: Fieldwork, 2017

We the young guys when we invite our friends to our homes, we do not want them to see our frail parents so we hide them **FM4**. From information in a report disseminated to the hospital, a participant added that we have noticed that the longevity of Ghanaians has increased through a survey. Ghanaians are growing older and our population is now between 25-30million **FB1**. Another participant added that, I can also say that due to good and proper medical care, the young ones are growing hence the increment in population **FM3**. Table 1-3 shows awareness of the increasing number of aged in our communities. About 66.6% said 'Yes' to the question and 33.4% said 'No'. The table also shows the responses on whether the aged were kept in the hospitals on festive occasions and about 67.9% responded 'Yes'.

4.3. Preparedness for Ageing

When participants were asked how the community planned for their future, they all responded that people planned through ensuring a certain amount of security by taking good care of their children for reciprocation of care in the future. Our society plan through their kids…they try to take care of their kids very well or any family member living with them, so that in their old age they can also rely on them for care. **FM6** Others said they knew people who planned by building houses so that they could retire and come back home to their loved ones before dying.

Table 3.
Quantitative data on nurses' awareness of issues of the aged.

Response	Yes (%)	No (%)
Awareness of increasing number of aged	160 (66.6)	80 (33.4)
Aged being sent to the hospital	163 (67.9)	77 (32.1)
Community ways of securing for the future		
Variable	N	Percentage
Having many children	45	18.8
Looking after other people's children	31	12.4

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Applying for person	25	10.4
Nothing that I know off	110	45.8
Others	29	12
Government plans for the aged		
Variable	N	Percentage
Cared for by the children	11	4.6
Housed in their homes	14	5.8
Look for caregivers for them	12	5
Nothing so far	203	84.6
Relationship between caregiver and aged		
Parents	65	27.1
Nephew/niece	135	56.2
No relation	33	13.8
Tenant	5	2.1
Living alone	1	0.4
Own sibling	1	0.4

Other participants said that those who plan do it without the knowledge of their family while others do not plan at all: What I see is, people think of residence, where they will spend the rest of their lives when they are old…a place to live after pension. Some do it secretly without their family's knowledge…others too plan their lives secretly by saving toward their funeral and buying of caskets **FM8**. Another participant added that, for those who travel to seek greener pastures…they make sure they build houses so that when they come back…they will get a place to stay…because they believe that it is good to die around your loved ones **FM6**.

One participant thought only the educated plan for their future, some of our people invest into businesses so that when they go home, they can be getting dividend from their investments and these are the educated ones. Apart from these nothing **FM3**. Tables 1-3 again shows perceived community ways of securing the future. 45.8% had no idea how the community members plan for their ageing, followed by 24.4% who said others look after people's children so that care will be reciprocated in future and18.8% said some people have their children as their future security.

4.4. Government Plans for the Aged

Participants were asked what government does for the aged; they all seemed to know about the national health insurance scheme (NHIS), the pension scheme, LEAP, and the EBAN because the programme are ongoing and they had a fair idea of them: the NHIS…it is a policy that is free for people 65 years and over, they enjoy free premium by the policy' **FM2**, 'to me this (pension) plan is limited to the literate i.e. those who have ever had formal classroom education. It is based on their active years' contribution they are given something (money) until they die'; **FM4**. Those who had heard of LEAP were not sure how it really worked: 'they are given some money (LEAP) especially for the poor to cater for themselves' FM4; 'the only programme l knows of is the LEAP but I do not know how it works; I heard they go and register for it' **FP1**. One participant thought only the disabled were eligible for the plan and he was corrected. I thought that programme was for disables **FM7**.

There was general agreement that 'the aged have been added', and one participant commented that, 'For my area, the LEAP is only for widows who are old…or who are above 65 years and more but for the male aged I have not heard anything', **FM6**. Another added that he had heard of the EBAN:' 'I also have heard that the aged are given priority whenever they go to the health facilities for attention or the EBAN for the state owned or metropolitan buses' **FM6**. Table 1-3 indicates responses on government planning for the aged, a majority (84.6%) said that government had no plan so far; 5.8% said the government plan was for the aged to be housed in their own homes and 4.6% said the government plan was for aged to be cared for by children irrespective of the environment.

4.5. Caring and Caregivers

When asked if they knew about the care and caregivers of the aged in their communities; all the participants agreed that there are some caregivers in their communities, and although these caregivers think they are doing a great job in caring but care to the nurses was not good enough. Some suggested that the root of the problem of poor caring practices was that the extended family system was breaking down and everybody was now busy, so the aged were left unattended. One participant said he had often seen old people in the company of young grandchildren about eight years old looking for directions to destinations and ending up in different parts of the town.

These was report that; 'Caring is not good because we are moving to the nuclear family system that is why we are facing these challenges. In the nuclear family setting, the aged are left alone at home so they need more caregivers. But with the extended family system their children leave their kids with their grandmothers so they tend to enjoy the interaction of these grandchildren. Meanwhile, in our setting because of our extended family system there was always someone who is self-employed and ready to care for the aged' **FP1**.

Another participant added that 'In our communities, women are more and they suffer the neglect than men so the government in its own wisdom targeted the women for the LEAP' **FM6**. Another described how a friend's grandmother was poorly treated by his own mother, People do neglect the aged and they leave them to their fate … because at their age they are branded as witches and then neglected. Just yesterday, a friend called me and complained about how his mother was maltreating his grandma she hardly cooks for her, so when he questioned the old lady on how she feeds she said she sleeps on empty stomach when there is no food she eats when there is food and stays when there is nothing and I think it is very much appalling' **FM2**.

Caring is traditionally done by females in the indigenous African home; participants were quick to add that it was appropriate for the female child to look after the aged in the community even through caring could also be done by a male child. Indicative comments

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were: 'Caring is the responsibility of the daughter' **FM4**. 'From where I come from, the aged stays with either the first born or the last born irrespective of the sex' **FM6**. In my community, it is the responsibility of the last born to care for their aged but if the aged has a daughter then the daughter will leave wherever she is and go and care for her parents … she must come and stay by running a routine between her aged parents and her nuclear family **FM3**.

Another participant reported that grandchildren were made to stay with their grandparents and he was an example, I stay with my grandmother; because of the low educational status of the community, they do not plan for ageing. What they do is that they rely on their husbands if they are alive then it is the responsibility of their husbands to take care of their household and everybody….So, when there is a girl child in the family…they will let the girl come and stay with her grandparents and help with the little things that they may need. When I was home, I did the house chores because my sister had left for school … but now another girl is there now'. FM7. Table 3 shows the relationship between caregivers and the aged they take care off. A majority (56.2%) was close family members of the second generation, and 13.8% of caregivers were not blood relations of the aged in their care. One aged person was reported to be living alone and another with a sibling.

4.6. Assisted Living

Assisted living illustrates the shift from caring as a humanitarian service to a business venture in the broader health care arena in the 1970s where it has become a consumer-driven industry that offers a wide range of options, levels of care, and diversity of services [31]. When asked what they thought about assisted living, participants asked what kind of nursing care entailed in the assisted living facilities. The PI took the opportunity to explain the concept of assisted living to them using the SWOT approach.

As participants deliberated among themselves and the PI gave them more time to discuss their fears and uncertainties. There were expressions of disapproval as to why people would want to give up their cultural role of caring for their own to be replaced by something, they had no idea off. Other participants felt that government should assign nurses to take care of the aged in their homes so that they could also attend to their spiritual needs. Another group was happy because they knew people who were looking for such places for their aged. There were also participants who were convinced that day-care would work but felt that there should first be a suitable policy for the programme before its inception.

4.7. Cultural Ideologies

Those who oppose the idea of assisted living thought that government should come out with a policy on care for the aged that would be binding on every household in the country. I have my reservations about this assisted living….You see, a lot of people will be running away from their responsibilities…..I suggest that there should be a policy or law before this programme comes off…so that everybody would be made to take care of their aged … and penalties accorded if those rules are breached or flouted; …if people neglect their parents, grandparents and it made known to authorities…these culprits would be punished…people who do not want to look after their aged could dump them there **FM7**.

I am not in support with this idea because when we were young, they took care of us….We were defecating and urinating on them and doing all sort of things on them so it is now time for us to also care for them. Now, that it is time for reciprocation of care we are trying to dodge our responsibility; leaving it for someone else to do….As my brother rightly said people will shed their responsibility to other people….My suggestion is if education will be effective on how to take care of the aged. I think it will be good **FM8**.

4.8. Programme Inception

There were various comments on the possible inception of the programme by participants: 'I saw this nursing in a foreign movie once and it was very fine. Due to our cultural beliefs, the old ones believe there is a spirit of the environment so they would not like to leave their environment. But if government too can do that for us it will be fine. Nurses can take nursing to their door step so that it will be like door to door nursing care. Caring for the spiritual needs of the aged is also very important so if they can train nurses, it will be very fine. Every month or twice a month a nurse can go and visit the aged at home and demonstrate family involvement in their care' **FM6**. 'Left to me, government must train more community health officers (CHOs) to handle the aged just like they are handling the children. The old people also believe that they are the custodians of the land … so if you ask her to go and stay somewhere it will not be proper. The uneducated would want their parents to stay in the house. Meanwhile the young ones cannot say they will not work to look after their aged parents so the government can train nurses solely for this programme to go around the homes to help with caring for the aged' **FM5**. 'In Ghana now, we are becoming enlightened so there should be education for people to be aware of these innovations.

It should be an in and out of the facilities and home setting. We must push this thing forward; there will be ups and downs of the programme while it is taking root. When it takes off…I believe all these challenges we are bringing up will be taken care off so long as we pay attention to them' **FP8**. 'The day care will be proper; our communities have been structured such that every community in Ghana has a community or social centre so the chief should agree to let his people to be trained…so that they take off the aged at the community centre…day-care type will be more feasible.

The day care will work; … it will be a place where they will have a lot of fun then they come home in the evening. This will work in Ghana' **FP3**. 'I also think the church can help…because in my church they are trying to use the social centre to be doing something creative for the aged. So, that the aged who can walk will come and play indoor games when they are bored at home then go back at the end of the day. Some of the tithes we pay at church is used to do this activity' **FP1**.

4.9. Funding

Participants offered time to comments on how the programme should be funded: 'As part of our pension scheme, we must be advised so that the same thing to be done on our aged facilities … we have complaints from the community about people neglecting their aged' **FP5**. 'Government can do it through private partnership so that it will be regulated like the health insurance system. This

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could be one aspect of the health sector, to make life complete' **FP4**. 'Government should go into partnership with private entrepreneurs so that they can handle this programme as a business entity' **FP3**.

Ehmm! We are being advised to secure other means of pension plans as workers in our active life: … So, if we are saying that government should take up responsibility it can also take up that part of setting up policies to care for the aged. Just like it did for the 3tier system of the existing pension plan so that such funds could easily be accessed. More so, the emphasis should be on social support. We are worried about people in the communities complaining on neglecting their aged parents but I also want to say that anybody who is sensitive enough to identify that their aged parents need care in such a home or secured services in a home or looking for someone to cater for their aged is supportive enough Ahhaaa!!! So, if we should promote this practice rather than undermine it from the scratch, we could go a long way' **FP8**.

As for Ghanaians, we will agree to pay for the something then we start and just to let it hang… an example is the mental hospital saga. People will bring their wards with promises … but when they go home that is all. They do not honor their promises and it becomes a burden for the government. We do not want such things to repeat itself because people would be dodging their responsibilities and start blaming the government when things go wrong, however there should be another way of reaching out to the aged through government's point of view. They should be in their own home environment for government to reach out to them through LEAP' **FM6**.

4.10. Acceptance of Responsibility

Questions that were missed from the FGD question guide for participants were captured in the questionnaire for respondents. Question on willingness to work in an assisted living facility was captured and answered by 240 respondents. Table 1-4 also displays the response of respondents to the establishment, and working in an aged-care facility or an assisted living facility, and willingness to work in an aged care facility or an assisted living facility. In the analysis, the variable score showed a statistically significant p-value of 0.043, showing there is an association between respondents agreeing to the establishment of assisted living and readiness to work in an assisted living facility. 97.9% agreed to accept responsibility to work when deployed, while 2.1% were not in favor of the idea.

In the descriptive statistics, there was statistically significance association between having knowledge of government policy and source of this knowledge with a p-value of 0.000. The Table indicated acquisition of information on the policy for the aged and how this information was acquired. A significant number of participants (39.2%) had no idea of any policy on aged care. Even though some claimed to be getting information about the aged, in most cases, from two or more sources. Less than a quarter of the participants said that, 'Yes', they knew about this policy from TV and radio.

Table 4.
Quantitative data on nurses interest in aged issues.

Establishment and working in an aged care institution				
Working in an aged care institution				
Establishment of an institution	Yes	No	Total	p-value
Yes	64.8	1.2	65.8	0.043
No	33.3	0.8	34.2	
Total	97.9	2.1	100	
Acquisition of information on aged policy				
	Does government have an aged care policy?			
How did you get to know this?	Yes	No	Total	p-value
Journal	2.1	2.5	4.6	0.000
Classroom	2.9	1.7	4.6	
TV /radio	23.3	5.8	29.2	
Workshop/ seminar	4.6	3.7	8.3	
Family/friends	2.5	3.3	5.8	
Others	8.3	39.2	47.5	
Total	43.7	56.3	100	

5. Discussion

This study set out to explore the perception of establishing and willingness of skilled nurses to work in an aged care or assisted living facility in Ghana. More than 90% agreed to the inception of the programme and to accepting responsibility to work in that environment. Although participants in the focus group were skeptical about feasibility of the programme, since family members had an obligation to take care of their own even when resources might be scarce. They nonetheless agreed that care for the aged was not good, due to the breakdown of the extended family system and its replacement by nuclear families. The nurses also acknowledged that health promotion strategies had increased the longevity of Ghanaians.

Appreciation was expressed for a documentary on changing family structures, showing that as people live longer and have fewer children, family structures are transformed, leaving older people with fewer options for care [32]. Population ageing is a phenomenon that resulted from declines in fertility as well as increase in longevity: two trends that are usually associated with social and economic development [33]. Participants did not know how community members plan for their ageing. Some said that caring for one's children and other people's children was used as a guarantee for the future in the form of reciprocated care when one becomes frail. According to Karlberg cited an Akan proverb to illustrate this: "If someone looks after you to grow your teeth, you must also look after him to lose his" [34]. This system has been a security for people without children, however, in a modernized society this system is difficult to maintain. Ultimately the system fails if these children move away to find work [35]. In a study in central Ghana, found that growing doubt around family solidarity meant that loyalty being shifted from lineage to conjugal family, and that the middle-class, urbanized

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Akan families had begun to keep non-nuclear relatives at bay, avoiding claims by the abusua on their income and possessions. Lack of awareness of government plans could be due to the nurses being fully preoccupied with workplace commitments than to get involved in community issues or communications on policy implementation from other sectors.

All respondents knew about the NHIS, which had a direct bearing on their job descriptions, as suggested by the Abuja Declaration which called for African heads of state to allocate at least 15% of annual government budgets to the health sector. In addition, it was expected that this financial support would increase substantially over the decades [36]. Assisted living will is a new caring practice in the Ghanaian health sector if accepted in the country, with study participants finding the concept difficult to understand until it was explained to them. As word got around about the concept in the course of the sequential data collection in the study, almost all participants (98%) showed interest in the establishment of aged care facilities and in working in such facilities or accepting deployment to one by their employers.

In terms of the technology acceptance model (as applied in the field of information technology and computing), which uses a simplified interpretation of beliefs that affect technology acceptance [37], there are two kinds of belief: perceived ease of use referring to the belief that using a particular system would be free of physical and mental effort, and perceived usefulness. Perceived usefulness is the degree to which an individual believes that using a particular system would enhance his or her job performance. These distinctions had been applied to the adoption of technology in workplaces, including health care facilities [38], in studies focusing on physicians [39], nurses [40], and other clinicians [41] as adopters of the new technology or programme.

Similar distinctions may help to explain the dilemma faced by nurses in this study as to ease of use of assisted living facilities, coupled with goal-driven concerns about whether output in their nursing care for the aged will enhance quality of care and improve the status of situation in the community. The concept of funding was rightly suggested as needing to be of the social security type, where the individual contributes to his/her ageing in line with government-controlled policy. It was also agreed by participants that all programme controlled by policies, well managed and sustained.

6. Conclusion

The purpose of this study was to explore the perception of establishment and the willingness of nurses to accept responsibility for working in an assisted living facility in Ghana. Issues that emerged were the existence of poor caring practices that would favours the introduction of assisted living, and the importance for study participants of perceived usefulness of people in the community, but also thought it would be worthwhile to try the assisted living concept because lives were at stake. There was also valuable input from respondents about the need for formulated policy to control the programme and using entrepreneurship to set it going. Study participants confirmed that there are some individuals in the communities who have no caregivers, and that for those who do, the care was not what they would consider adequate.

This suggests that this programme, through its multidisciplinary approach to nurses, caregivers and clients, may be meeting needs in the metropolis.

7. Strengths and Limitations of this Study

- Convenient purposive sampling procedures were followed making data collection a bit easier for the research team.
- Scheduling the FGDs to fit nurses' work schedules, workloads and distance from home was difficult, and although PI and assistant conducted three FGDs, two came out well but the third was disrupted by noise from construction work in a last-minute change of venue, affecting the data quality.
- The nurses also complained about the number of pages to be read, and a lot of distractions from their clients.
- Problems also arose in trying to coordinate focus group meetings with changes of shift and we also recognized researcher impact on study participants.

Ethical Approval

The study was approved by the Humanities and Social Sciences Research Ethics Committee of the University of KwaZulu-Natal (HSS/0608/016D) in South Africa and the Dodowa Health Research Centre (IRB Ghana Health Services) of Ghana (DHRCIRB/06/06/16). Voluntary participation was accorded with written and signed consent.

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