An Empirical Study of Group Home Care for Older Adults with Dementia

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Abstract

This study aims to: 1. exemplify the effect of group home care for older adults with dementia and 2. clarify the factors contributing to the effect. The present study is based upon a case study of 5 residents of a group home for older adults with dementia. As the case study proved the effect of group home care for older adults with dementia, the result was analyzed with 5 frameworks; ADL and IADL, roles in a group, emotion, communication, and behavioral and psychological symptoms of dementia: BPSD. For the result, the factors of the effect of group home care are summarized as follows; respect for individuality—individualized approach and protection of privacy—, environment—physical, psychological and social environment—, effectiveness of a group—grouping and group dynamics—, continuity of life—normal life and life as the past—, and a group home as pioneers of dementia care.

Key Words

Dementia Care, Group Home for Older Adults with Dementia, Group Home Care

I. Introduction

Today, Japan is confronting rapid aging, and the number of older persons requiring nursing care is increasing. The number is estimated to 2.8 million in 2000, 5.3 million in 2025 (Ministry of Health, Labor and Welfare 2003). Especially, it is prominent that the number of older adults with dementia is increasing because the most striking risk factor for dementia is age. The study group of elderly care (2003) pointed out that around 50% of older adults required nursing support or care and around 80% of institutionalized older adults are demented to some extent.

However, in Japan, many older adults are losing their dignity, interpersonal relationships, and “normal” lives because of dementia. As services for older adults with dementia are not enough in quality and quantity, their family members have to take care of them for long term. And when the family caregivers are pushed to physical and mental limits, many of them resort to using large scale institutions. But, most of these institutions don’t provide proper care for each older adults with dementia.

Today, a group home for older persons with dementia is attracting attention as one of the solutions to these problems. Different from large scale “institution”, a group home provides care which fits for each situation and conditions of the residents.

Until now, it has been reported in varied forms from the fields that group home care for the older adults with dementia achieves remarkable effects. However, most of the studies conducted in group home care have focused on particular abilities of older adults with dementia or have been substantiated temporarily or on a trial basis.

Therefore, this study aims to: 1. exemplify the effect of group home care for older adults with dementia and 2. clarify the factors contributing to the effect.
II. Method and the field of the study

In this study, case studies on 5 older adults with dementia have been conducted for 2 years at O group home for the older adults with dementia, Kobe City, Hyogo Prefecture. As for the case studies, the framework was picked out from the results of the literature review, analysis from the previous study, and focus groups on family members of group home residents. The details of the field and research are given below.

1. The field of the study

O group home, a three-story group home for older adults with dementia holds up to 27 residents and was established on a residential street in Kobe City, Hyogo Prefecture in October 2002. Each unit has 9 single rooms of 12.15 square meters each, and residents can choose western style or Japanese style. Each unit has a shared living room, dining room, kitchen, bathroom, and with 4 or 5 restrooms. The building was designed and built exclusively for a group home, and wooden materials were used in plenty so residents are able to live in Japanese style atmosphere of which they were used to. As it is free of barriers, residents can continue to live even if they are bound to a wheel chair. Furthermore, each unit has its own entrance that heightens each unit's independent feel.

2. Focus group

For the sake of creating the framework for the case studies, focus groups were conducted with the family members of the O group home residents in September 2003 and October 2004. Eighteen family members from 13 families attended the first focus group and 15 family members of 13 families for the second focus group; both groups were moderated by the author. The questions were on the details prior to living in a group home and the changes which occurred after living there.

3. Case studies

Case studies were conducted on 5 residents at O group home. Their change seen during the 2 years since admission to the group home was analyzed using the framework. As for the study's data, case records reported twice a day, care plans and their evaluations, documented entrance interviews, interviews with family members, staff and care managers and information obtained by the author from the field work at O group home for 2 years were used.

4. Process for choosing the field and the cases

As studies on dementia care are conducted with personal data of the older adults with dementia, researchers have to build relationships of trust with the older adults and their family members and the field (i.e., the group home) for the sake of getting the correct data. Therefore, in this present study, O group home was selected as the site for the study since the author has been engaged in the foundation and management of the group home as a director including designing, planning project programs, selecting residents and staff, and so on.

The cases were selected from the residents of O group home who had lived there more than 2 years, and the levels of care required, physical abilities and dementia, and the prior residences were also considered. To avoid the biases made by the relationship between the author and the group home, the data from multiple information sources with a focus on the care records were used for the case studies.

Furthermore, consideration was given towards the handling of the data gathered through the study, and the study was confirmed in writing by the O group home, the cooperation of social welfare which is the administrator of the group home, and the family members of the candidates of the case studies.

III. The framework of case studies and its theoretical background

Effectiveness of group home care for the older adults with dementia have been pointed out by various discussions (Toyama 2000; Hibino, Sasaki and Nagata 2002; Tokyo Dementia Care Research and Training Center 2002) and reports from the fields of dementia...
care (Ishikura 1999; Tokita 2002). Additionally, at the focus groups conducted for the present study, many opinions on group home care as effective for improving the conditions of older adults with dementia were expressed: “As I visited many kinds of services for older adults, I found group homes as the most decent in providing human services.” “Though I had worked for the elderly care services for 13 years, I had thought that older adults with dementia were happy because they couldn’t understand anything. But, when I became a family member of older adult with dementia, I realized the importance of heartwarming care.”

Consequently, based on the results from the literature review, analysis from the previous studies and from the focus groups, the effectiveness of group home care was classified into 5 perspectives: 1. ADL and IADL such as physical functions, social activities, motivation, self-esteem, and so on; 2. Roles in groups such as roles at a group home, purpose in life, significance of existence, and so on; 3. Emotions such as expression, affection, and so on; 4. Communication, verbal and nonverbal; 5. BPSD, behavioral and psychological symptoms of dementia. An overview of the theoretical background of the framework is detailed below.

1. ADL (Activities of Daily Living) and IADL (Instrumental Activities of Daily Living)

Core symptoms and peripheral symptoms of dementia have various effects on daily livings of older adults with dementia. In early phase of dementia, IADL such as impediments of driving and taking public transportation, shopping, cooking, doing household chores, taking medicine, managing money, and so on were observed. Since IADL requires various complicated movements, there is still difficulty even if the physical abilities for IADL are maintained.

At the advanced stage of dementia, people with dementia forget how to act and become incomprehensible to meanings of actions because of memory disorder. They have impairments on basic activities of daily living (ADLs) such as bathing, dressing, walking, toileting, eating, and so on. Furthermore, at the most severe stage of dementia, physical abilities are disabled by dementia including controlling excretion and walking.

To maintain abilities of ADL and IADL of older adults with dementia, care for supplementing and preventing the abilities and functioning disabled by symptoms is important. At a group home, personal care which respects the resident’s self-esteem and self-motivation is provided on the comprehension of each resident’s condition to allow the resident’s residual functions exert at a maximum level. As the word “daily rehabilitation” expresses, daily living itself plays a role in rehabilitating physical functions of older adults with dementia.

2. Roles in groups

Development of dementia disables older adults’ ADLs which they used to do without any problems until then, and causes mistakes in daily lives. As a result, most of the actions and roles of older adults with dementia at home and in society are suppressed for reason of “improving efficiency in daily tasks” or for “their own safety.” Cars and Zander (1988) pointed out that the feelings disdain and anger from others as the older adult’s dementia progresses let the older adult recognize his/her own declining intellectual function, feel inferior, and lose their self-respect.

However, a feeling of “being useful” is very important for human beings, and it is also necessary for older adults with dementia to have and perform appropriate roles and be approved by others in order to rebuild their own lives and reconstruct their personhood.

Group home care is effective in creating roles for older adults with dementia in societies and families which sustain their own lives. Hashimoto (1999:161) points out “(at group homes) each resident has a role in his/her life to the extent possible and importance is placed on memberships in which people help each other.” Furthermore, group home for older adults with dementia has a staff with professional education on dementia care who provides care in small groups which relieve residents from societal rules and regulations and allows them to exert their own abilities.

3. Emotion

It has been pointed out that core symptoms of de-
1. decline motivation, self-esteem and spirit, 2. impair cognitive function, and 3. impair emotional function, which creates adverse effects on emotions of older adults with dementia (Hibino, Sasaki, and Nagata 2002). Declining motivation, self-esteem and spirit, which can be observed at an early stage of dementia are caused by the decline of self evaluation with problem with performing daily tasks and making mistakes or having to overcome hurdles at work. With the progression of the disease, especially when the faculty of orientation for time, place and person is impaired, asense of insecurity or tension is inevitable. In addition, older adults may fall into a state of panic from simple stresses from sound, voice, light and space because the acceptance of stress in daily lives declines with the progression of the disease.

Though various impairments which exert a harmful influence on emotion of older adults with dementia are attributed to core symptoms of dementia as indicated above, responses from others and the environment surrounding older adults with dementia exert an influence. For this reason, the effect of group home care is expected to improve emotion of older adults with dementia. For example, the suppression of motivation, self-esteem and spirit, which is observed at an early stage and is easily overlooked, fixes the older adult in a state of paralysis, and increases his/her symptoms. But, at a group home, appropriate care based on care plans of residual function assessment motivate each and every resident and prevent his/her symptoms from worsening. Furthermore, the effect of social facilitation by making the most use of group dynamics has a useful role in motivating residents.

For impediment of faculty of orientation for time, place and person, which occurs at the advanced stage of dementia, to have daily routines, a homelike environment with minimal confusions, and human relationships with familiar residents, staff and community residents at a group home all have a useful role. Furthermore, for a disordered function of emotion, the environment and personal care fitted for each and every resident of group homes can prevent panic and state of insecurity of older adults with dementia.

4. Communication

Communication is a necessity for human beings living in a society or group. However, communication of older adults with dementia are impeded by decline of physical functioning such as vision, hearing, language ability; decline of conversation abilities such as understanding rules of the language spoken, keeping up with topics and decline of social abilities such as understanding the unspoken agreement of a culture and society. Dawson, Wells and Kline (1993) point out about verbal and nonverbal communication of older adults with dementia as follows: 1. ability of human relations is affected by dementia, 2. impediment of ability of human relations put older adults with dementia at risk of social isolation, 3. difficulty of communication is the most common problem among family members of older adults with dementia. That is to say, family members of older adults with dementia and staff require special knowledge and technique because communication is a very important action in maintaining social life for older adults with dementia. Melin and Olsen (2000) point out 22 items as elements which have adverse effects on communication of older adults with dementia: "disorder or depression of sensory function" "new or unfamiliar situation" "situation of inadequate language understanding" "condensed environment or field of activities" "tenseness or sensation". That is to say, communication of older adults with dementia is one of the most important indicators to measure the effect of group home care.

At a group home, residents communicate amongst themselves directly or through the intermediation of staff. So, the gap between cognition world of older adults with dementia and world consisting others is diminished and prevents a sense of anxiety or stress.

5. BPSD (Behavioral and Psychological Symptoms of Dementia)

Dementia is a collection of symptoms caused by various diseases such as Alzheimer's disease, cerebrovascular dementia, Lewy body dementia, and so on, and its symptoms are divided into core symptoms and peripheral symptoms. Core symptoms are the symptoms which most older adults with dementia have such
as disorder of memory, cognitive dysfunction, apraxia, agnosia, and so on. Peripheral symptoms are the symptoms which not all older adults with dementia have, and can be divided into psychological symptoms such as state of depression, decline of motivation and delusion, and behavioral symptoms such as wandering, verbal abuse, violence, and pica behavior. Especially, behavioral symptoms have also been called “problem behaviors”.

However, recent studies point out that BPSD are caused by the environment surrounding older adults with dementia and quality of care. Kitwood (1997) points out that in the “old culture,” BPSD was to be managed skillfully and efficiently, but in the “new culture,” BPSD should be viewed primarily as attempts at communication, and is necessary to understand the message for responding to the unmet needs. Furthermore, Hibino, Sasaki and Nagata (2002) point 3 inciting causes of BPSD: 1. physical triggers such as deconditioning, chronic diseases, drug side effects, 2. psychological and social triggers such as isolation, anxiousness, fear, suppression, stress, 3. environmental triggers such as too big entrance, too long corridor, too large dining. It is expected that group home care improves such symptoms.

In the cases that follow, BPSD are caused by the situation and environment surrounding older adults with dementia, and as Sasaki (2001) points out, dementia care at large scale institution was “misguided specialization without regards for life” and created BPSD among older adults. In addition, Hashimoto (1999) and others reported moderation and improvement of BPSD in many cases with the introduction of group home care in dementia care. Thus, BPSD is an important perspective to analyze the effects of group home care.

IV. Case studies

Case studies on 5 residents of O group home were conducted for two years, and their changes after they started living there were documented based on the different frameworks for this study. The results are as below (Table.1).
### Table 1: The result of the case studies

<table>
<thead>
<tr>
<th>Age/Sex</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Required Level</td>
<td>85/Female</td>
<td>85/Female</td>
<td>84/Female</td>
<td>81/Female</td>
<td>89/Female</td>
</tr>
<tr>
<td>Level of Disability</td>
<td>1A</td>
<td>1A</td>
<td>2A</td>
<td>1A</td>
<td>2A</td>
</tr>
<tr>
<td>Level of Dementia</td>
<td>IIb</td>
<td>IIb</td>
<td>IIb</td>
<td>IIb</td>
<td>IIb</td>
</tr>
<tr>
<td>Prior Residence</td>
<td>Care house</td>
<td>Care house</td>
<td>Home</td>
<td>Care facility</td>
<td>Home</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ADL and IADL</th>
<th>Entering</th>
<th>6 months</th>
<th>12 months</th>
<th>18 months</th>
<th>24 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entering</td>
<td>She didn’t like chores.</td>
<td>She didn’t care much about IADL.</td>
<td>She had walking difficulty and incontinence.</td>
<td>Walking was difficult because of fracture.</td>
<td>Impaired IADL made living alone difficult.</td>
</tr>
<tr>
<td>Roles in a group</td>
<td>She didn’t do good for others.</td>
<td>She didn’t have to play a role.</td>
<td>She was dependent on her daughter.</td>
<td>She didn’t have to play a role.</td>
<td>Interaction with others was scarce.</td>
</tr>
<tr>
<td>Emotion</td>
<td>She was very proud and thus isolated.</td>
<td>She was inflexible and didn’t open up.</td>
<td>She acted like a victim.</td>
<td>She often expressed loneliness.</td>
<td>She realized her own dementia and emotionally let down.</td>
</tr>
<tr>
<td>Communication</td>
<td>She was always enjoying herself.</td>
<td>She had poor expression because of depression.</td>
<td>She had to smile sometimes.</td>
<td>She got to smile sometimes.</td>
<td>She took on a soft expression.</td>
</tr>
<tr>
<td>BPDS</td>
<td>She had a delusion and fantasy.</td>
<td>She had a depression state, panic and agrypnia</td>
<td>She desired returning and refused bathing.</td>
<td>She had a delusion and agrypnia.</td>
<td>She had a delusion and agrypnia.</td>
</tr>
</tbody>
</table>

**ADL and IADL**
- Entering: She didn’t like chores. She didn’t care much about IADL. She had walking difficulty and incontinence.
- 6 months: She got to wear skirt, which she never wore before. She sometimes lost her glasses and hearing aid. She sometimes had a wobble and fall.
- 12 months: She was able to speak loudly. She was able to manage them. She was able to go out with a walking aid. She often appealed “tired”.
- 18 months: Opportunities to go out increased. Opportunities for going out increased. She got to go out positively. She got to read a newspaper and magazine.
- 24 months: The dietary intake increased. She was living in comfort. Opportunities for going out increased. She had more incentive to walk. She got to read a newspaper and magazine.

**Roles in a group**
- Entering: She didn’t do good for others. She didn’t have to play a role. She was dependent on her daughter.
- 6 months: She sometimes did tea ceremonies. She cared for flowers and folded laundry. She didn’t play a role actively.
- 12 months: She joined cooking and laundry actively. She took care of an acquaintance. She got to give some help. She appealed “tired” and didn’t have a role.
- 18 months: She led other residents. She got to help other residents. She sometimes joined cooking and doing dishes.
- 24 months: She helped other residents actively. She joined cooking and laundry actively. She got to join doing the dishes.

**Emotion**
- Entering: She was very proud and thus isolated. She was inflexible and didn’t open up. She acted like a victim.
- 6 months: She showed her appreciation for relatives. She was sometimes acrid. She had poor expression because of depression.
- 12 months: She became a cheerful character. She got to smile sometimes. She got to smile sometimes. She took on a soft expression.
- 18 months: She got to express her emotion honestly. She accepted living in a group home. She got to smile often. She took on soft expression.
- 24 months: She was always enjoying herself. She was most moderate after dementia appeared. She was moderate. She got to not complain.

**Communication**
- Entering: She had a trouble with human relations. She had trouble with human relations. She was always alone and nervous. She wasn’t active for communication. The range of communication was limited.
- 6 months: She was afraid of a certain resident. She became friends with Ms. A and Ms. B. She cared about others thinking too much. She visited other resident’s room and talk.
- 12 months: She wasn’t afraid of her any more. She often talked with acquaintances. She didn’t communicate with others. She often stayed in her room.
- 18 months: The range of communication expanded. The range of communication expanded. She had an interest for others. She often stayed in the living room.
- 24 months: “I enjoy living with other residents” “I moved into a very good place” The relationship with others was expanded. Communication became stable. The range of communication expanded.

**BPDS**
- Entering: She always complained to relatives. She had a delusion and fantasy. She had a depression state, panic and agrypnia. She desired returning and refused bathing. She had a delusion and agrypnia.
- 6 months: She no longer complained. She sometimes had a delusion. She had a depression state, panic and agrypnia. She desired returning and refused bathing. She had a delusion and agrypnia.
- 12 months: Nothing Particular She scarcely had a fantasy. She scarcely had an agrypnia. She didn’t refuse bathing as before. She scarcely had a delusion.
- 18 months: Nothing Particular She scarcely had a delusion and fantasy. She scarcely had BPDS. She didn’t refuse bathing as before. She sometimes had an agrypnia.
- 24 months: Nothing Particular Nothing Particular Nothing Particular Nothing Particular Nothing Particular She scarcely had an agrypnia.
V. Discussion

The results of the case studies are analyzed with 5 frameworks; ADL and IADL, roles in a group, emotion, communication, and BPSD. Furthermore, by analyzing the effect of group home care on their changes, the contributing factor of its effect is clarified.

1. ADL and IADL

Though ADL and IADL consist a wide variety of items, it became clear from the viewpoint of ADL and IADL that improvements were found in the 5 residents during the two years since they started living in a group home. Furthermore, looking at each case in chronological order, levels of improvement differ depending on the causes of decline in functioning.

First, the improvement of “disuse syndrome” was found at an earlier stage after moving. “Disuse syndrome” is a decline in ADL and IADL because of lack of motivation and opportunities, even if physical function is maintained. For example, Ms. A choosing to wear a skirt or speak louder, and Ms. B proactively going outdoors correspond to the improvement in “disuse syndrome”. Improvement in the next stage can be found in the “behavioral disorder of dementia” of which behavior disorder is caused by declining executive function and disorientation even if physical function is maintained. For example, Ms. B and Ms. E were able to take care of personal belongings such as glasses and artificial dentures. Finally, behavioral disabilities caused by declining physical functioning took longer time to begin exerting the effects of group home care. Cases of Ms. C and Ms. D whose walking staggered and was in imbalance got well again are examples. However, it is extraordinary that recovery of physical functioning was observed without special physical rehabilitation.

The major factor for improvement in ADL and IADL observed in the case studies was the “motivation” of residents to perform tasks. In all 5 cases, residents gradually got motivated to perform tasks which they never did before they entered the group home. It is suggested that the environment of a group home where its care aims to “use residual function” is thought to be the reason behind the change. At O group home, care plans made by the staff in charge and care planners with the input of family members every 3 months, motivates residents to perform ADL and IADL depending on their changing abilities. In addition, the design of O group home came reduces behavior disorders of older adults with dementia. Bathrooms are placed close to bedrooms and plated name signs make it easier for residents to find their rooms greatly reduced, for example, the symptoms of Ms. E. The staff also play important roles to reduce behavior disorder; Ms. B and Ms. E were able to take care of personal belongings such as glasses and artificial dentures because the staff provided proper care based on their residual functions. Furthermore, it is important to note that daily life at a group home itself produces effects to improve the level of ADL and IADL. Daily participation for housekeeping and securing opportunities to go outdoors motivate residents allow them to have control over disuse syndrome.

2. Roles in a group

Most of the older adults with dementia, regardless of their environments, lose their roles in their daily lives, groups or human relationships they belong. The 5 residents from the case studies are not an exception; they were not able to exercise residual functions and play their roles at the places they had lived prior to entering the group home such as care houses, their own homes, and healthcare facilities for the elderly. Analyzing from the viewpoint of “roles in a group”, their change after they started living at the group home showed their roles expanding.

Classifying the changes into 4 steps, analyses are as below. First, at the early stages, the residents played “the roles for themselves” such as washing dishes they used or folding laundry. For example, Ms. A demonstrated tea ceremonies for other residents at tea time, and Ms. B and C took care of flowers and folded other residents’ clothes. At the 3rd stage, the residents started providing direct assistance to others such Ms. A leading others, Ms. B taught a friend who was later admitted to the home on how to live there and Ms. E showed concern for other residents. And, at the last stage, the residents played roles which they cooperated with others, typi-
fied by their joining to cooking and washing dishes after meals with other residents.

Based on the analyses of these 4 stages, the effects from living in a group home such as “self-determination” and “use of residual function” are suggested as factors of the 1st stage. It is because, prior to living in a group home, their daily actions were limited. At the 2nd stage, to expand the intention of the roles they play from only for themselves to others, expansion in the range of communication is necessary and the opportunities of “interactions with others” must be reserved properly. Residents who play roles for others can keep their “pride,” “dignity”, and one of the most highest psychological desire of “being helpful to others” through satisfaction gained from appreciative words from others and having a central role at events. Consequently, the gist of the roles played for others become more direct, and the residents move to the 3rd stage. Finally, to arrive in the final stage, better “human relationship” and “confidential relationship” have to be created between the residents and staff. When there are shared common goals and cooperative work such as cooking and washing dishes, the effect of social facilitation due to group dynamics appeared, and consciousness, attitude and action were reinforced.

3. Emotion

Most older adults with dementia have some difficulties in their daily lives and have a sense of being estranged, so it is difficult for them to express their emotions. However, in this research as well as others, the cases which remarkable changes were found after the older adult was admitted to a group home often showed that most of the family members of the residents point out “emotion” as having the most significant change. The changes of emotion for 2 years in 5 cases are classified into 3 steps, though individual differences are found in paces of improvement.

At the first stage, observations show that older adults with dementia try to hide in their shells, don’t express their emotions often, and sometimes reveal aggressive emotion or take an aggressive stance. The period Ms. B was opinionated, shut her heart, and took a hostile attitude, and the period Ms. D didn’t smile often im-
mediately after she was admitted are examples. At the 2nd stage, residents gradually show emotions, especially pleasurable emotions, and bright expressions. The cases of Ms. A, Ms. B and Ms. E arrived at this stage a half year after they entered the group home, and the cases of Ms. C and Ms. D took more time. At the final stage, aggressive emotions and attitudes conceal themselves, and instead, “moderate” expression were observed. In the interviews with the family members, many of them said “[S] he is in the most moderate period now”.

At a group home, proper care is provided to use residual function at a maximum and let the residents live with “pride” and “dignity”. And, to facilitate communications among residents, consideration is given to the soft and hard factors so residents don’t feel a sense of estrangement or loneliness as much. To improve the emotions of older adults with dementia, these are the factors which indicate the effectiveness of group home care. Furthermore, looking at the changes of “emotion” in 5 residents for two years from the viewpoint of “validation” proposed by Feil (1993), the time when they mentioned “acceptance” of living at the group home, in some cases, were the turning points of their emotions. For example, in the case of Ms. A, she requested to get rid of her home after six months she started living in the group home, around when bright emotions, especially smiles, were observed. Moreover, in the case of Ms. B, the state of her emotions improved greatly from the time when she said, “I thought it was a lonely place when I came here, but that feeling had gone away today.” This is because the resident with cognition disorder, at the 1st stage, recognized the importance of her existence again, as she gained sympathy from the staff and other residents.

4. Communication

Although the places they had been before they came to the group home are different, the 5 residents from the case studies had problems concerning communication. For example, Ms. A and Ms. B lived in care houses where it is difficult for older adults with dementia to live; they were isolated because of money troubles with other residents and had difficulty making relationships with older residents. Moreover, Ms. C and Ms. E, who
lived at home, had poor interpersonal relations and communication was minimal regardless of whether they lived with family members or not.

Looking at the conditions of 5 residents from the viewpoint of “communication”, the range of communication expanded through 3 stages though there were differences in speed. At the 1st stage, communication was minimal, and there was no one who talked friendly with them. Though the main people they communicated were staff and family members, the residents sometimes feared a certain person or made troubles with others as shown in cases of Ms. A and Ms. D. At the 2nd stage, a certain familiar resident appeared. However, at this stage, communication was limited to one-to-one relation or with staff. So, as shown in the case of Ms. E, residents visited other bedroom and talked. At the 3rd stage, the range of communication expands and some residents have conversation on a friendly, regular, and continual basis.

As found in the cases of Ms. A and Ms. B who had lived in care houses, it is difficult for older adults with dementia to have communication in the group consisted by older adults without dementia. However, the environment surrounding older adults with dementia in group homes consists of residents who are older adults with dementia, staff who took professional training, and communities with understanding towards dementia. For this reason, entering group homes is “healing” and “forgiveness” for older adults with dementia, which becomes factors for improving communication (Chiba 1999).

The residents who are able to communicate with staff make familiar human relations with certain residents as the next step. As it is difficult for older adults with dementia to develop personal relationships in group and environment of larger dimensions, it is considered that this effect is caused by “small-scale” and “homely environment”. Additionally, the range of communication expands as time advances, and the residents develop human relations with a number of other residents or an entire unit of residents in some cases. At this stage, the role of staff is also very important. In groups consisted by only older adults with dementia, it becomes difficult to have communication because of symptom progression and deterioration in hearing. So, human relations must be formed with coordination of conversation among a number of residents by staff.

5. BPSD

The 5 residents of the case studies suffered from certain BPSD such as a change in personality, delusion, heteroptics, depression state, panic, prowling, insomnia, and so on, when they started living at the group home although there were differences in degree and type. However, with time, it became clear that these symptoms diminished and occurred less frequently. As mentioned earlier, BPSD have varieties and differences among individuals on existence or nonexistence, frequency and types. The 5 residents were no exception. It is the feature of the change of 5 residents from the viewpoint of “BPSD” that big differences were found in the process of improving symptoms. Common points found in the cases were that it took longer to improve “psychological symptoms” than “behavioral symptoms”.

It is pointed out that the cause of BPSD is not only the disease which causes dementia, but also physical and personal environment. Moreover, other 4 viewpoints used in the case studies can also be considered as the causes of BPSD. The factor of improvement of BPSD can be analyzed as “hard” factors such as physical environment and the “soft” such as personal environment.

First, as for the physical environment, group home O was designed in response to the symptoms of dementia, which indeed contributed to the improvement of BPSD. For example, Ms. C who had “apraxia”, one of the core symptoms of dementia, showed depressive symptoms because she couldn’t understand how to use the equipments when she returned home for a while. However, at the group home, where things were arranged for the older adults with dementia accordingly, she never panicked because she was able to understand how to use equipments. Moreover, “homelike dwelling environment” such as privacy-conscious bedrooms allowing favorite furniture and keepsakes to be brought in, helps to facilitate the conscious of “ whereabouts” of residents and plays important role to melt desire of
returning home.

Furthermore, the “soft” factors such as tailored “personal care” and “low-stress human relations”, which large-scale traditional institutions couldn’t provide, became an important factor of improving BPSD. For example, agrypnia of Ms. C and Ms. E improved because they had a good distribution of chores and occasions to go outdoors, they didn’t have unneeded sleep, and were able to feel tired. In the case of Ms. D, who sometimes refused bathing because she felt ashamed of receiving bathing care, build “familiar human relations” with staff. Ms. D’s refusal to bathe was controlled. Moreover, Ms. A, who often had her own way before she entered the group home, was able to gain “satisfaction” and “pride” for living at a group home, and the symptoms were resolved.

VI. Conclusion and future tasks

As above, the results of case studies and discussion clarified the effect of group home care and the factors of the effect. The factors are summarized as follows; 1. respect for individuality–tailored care for residents, a life at a group home which guarantees privacy, self-determination and freedom; 2. environment–the environment with consideration for symptoms of dementia which is not “facility like” or “hospital like” but homely and cozy; 3. effectiveness of a group–human relations in a small group which allow older adults with dementia to spend a life with “role” and “responsibility”; 4. continuity of life–care provided with understanding of lives of older adults with dementia, human relations with family members, friends and acquaintances, and continuity of community life; 5. a group home as pioneers of dementia care - paradigm shift from old “large scale, uniformed and efficiency-oriented” care to “personhood oriented” care.

As the present study was conducted with the limited method, the case studies of residents of a group home for older adults with dementia for 2 years, the study will be continued.

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