A RETROSPECTIVE STUDY ABOUT INSTITUTIONALIZED ELDERLY LIFE CONDITIONS IN THREE SOCIAL CARE CENTERS

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Abstract

A retrospective study was made on 195 institutionalized elderly people and was carried out between 2002-2006 in three social care centers from Galati county: "Sf. Spiridon" retirement home (A), "Stefan cel Mare" social care center (B) and Medical-social center (C). The aim of this study is to find out the real social life conditions of institutionalized elderly, the shortcomings and positive aspects of their existence, in order to design future measures to improve quality of elderly life in all aspects. Actual quality of life was assessed by, taking into account physical and psychosocial environment, quality of elderly social care, satisfaction degree of assisted persons in relation to living conditions and existing relationships, their health state, as well as to identify the causes that led institutionalization of such persons As working tools were used: individual questionnaire, training manual, sampling lists, summary tables. The study undertaken in Romania confirmed that elderly coming from "Sf. Spiridon "retirement home have the highest average age (up to 75 years old). Loneliness was the main reason which caused elderly admission for institutionalization in three nursing homes (49.6% among the elderly in the Sf. Spiridon retirement home (A), 43.2% for those from "Stefan cel Mare" social care center (B) and 38.1% of the elderly from Medical-social center (C). Other important reasons were represented by lack of housing and insufficient storage house space. The highest elderly percentage who came into social care centers A, B, C on their self will is 85.3%, 64.9% and 45.2%, respectively.

Keywords: elderly, social care, individual questionnaire, institutions, mutual assistance.

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Introduction

The aging process is associated with a low degree activation of immune system, which emphasizes the fragility of the elderly. These results induce a state of increased vulnerability, which is responsible for the inability to maintain normal physiological balance and to respond to the stress (Mates, Perez-Gomez & Nunez de Castro, 1999: 595-603). Main signs of fragility depend on poor nutritional status and low – intense activities that elderly can perform. As a result, install a spontaneous weight loss of more than 5% per year, lead to lower muscle mass and strength, increases fatigue and decreases physical activities performed by elderly. These changes can also be the result of contacting chronic diseases which affects quality of elderly life; autonomy falls and jeopardizes life at home, which ultimately leads to institutionalization (Boirie, Morio, Caumon & Cano, 2014: 1-9). Many recent studies have shown that the elderly persons presents a increased oxidative stress state and an weakened antioxidant defense system (based on enzymes SOD -Superoxide dismutase, GSH-Px – Gluthatione peroxidase and CAT - Catalase). This common condition in the elderly is responsible for chronic diseases installing and progression: diabetes, atherosclerosis, dyslipidemia, hypertension, sarcopenia, osteoporosis, cataracts, joint inflammation (Oliveras-Lopez, *et al.*, 2013: 234-242).

Sarcopenia, which consists in gradual loss of muscle mass, occurs in 15-50% of elderly and is directly associated with sharp decrease in muscle strength and physical activity, and thus with a higher mortality (Chwang, 2012). Also cognitive function decline and senile dementia are frequently encountered diseases in the elderly.Other studies argues that oxidative stress and inflammation are the mechanisms involved directly in cognitive function loss (Lee *et al.*, 2013). Accumulated data over the years reported a longevity increase which involves a major change in health system, that need to be prepared to satisfy the requirements of older people, at a community level. It's about solving the major 4 problems of geriatrics: memory loss, urinary incontinence, depression and falls/immobility and also chronic diseases problem. Prevention of chronic diseases and their screening takes place in the Primary Health Care (PHC) units within the healthcare system (WHA, 2012: 61-64).

Persons aged 80 years and over which frequently raises health and social care problems, shows a higher morbidity, especially by chronic diseases, which it is in fact multiple morbidity (Mărginean *et al.*, 2004). The main objective to be achieved, regarding the elderly persons, is that they live a healthy, active and independent life. To achieve these goals is further recommended to promote prevention measures: age appropriate healthy eating, physical and intellectual activity, which must be initiated already during the youth and continued to old age (CSE, 2006: 9-10). In Romania, the protection of poor elder individuals and families is ensured by a range of benefits and social care services: social assistance, emergency aid,

social canteen, and also by individual social services or special institutions for the elderly (Mănoiu & Epureanu, 1996). Main types of services addressed to elders in Romania are: day care centers, nursing homes, shelters, social assistance at home.

The property, in the elderly case, is not only a comfortable living space, but often has a emotional value relating to personal life experiences, to family, friends, neighbours, moments of life (Georgescu, 2010). Spouse and family are the first elderly caregivers, in the event of disability (Angel & Himes, 1992: 496-521). Physiological wellbeing and overall quality of live perception by elderly persons, tends over time to decline (Maria & Tengku, 2010: 32-40). The family who easily and without justification isolate an elder does not only commit an act of ingratitude but also undermines his health, urges the involution and induces illness (Rugina, Duda & Blanaru, *apud.* Georgescu, 2010). The spatial and territorial appropriation of the new residential universe, which is identifiable by the use frequency of the possessive pronouns and affiliation verbs, is achieved in several ways; some are the adaptive expressions of taking possession and emotionally invest in the room and in the places in the home, while others prove the inability part with the old house (De Jong, Keating, & Fast, 2015).

A consistent social support of institutionalized elderly is needed. Academic theoretic definitions add that the recipient should have a perception of someone caring for them and a resultant sense of well-being (Hupcey, 1998). Hupcey enumerated the factors required for social support as follows: (a) the act of providing a resource, (b) the recipient having a sense of being cared for or a sense of well-being, (c) the act having an implied positive outcome, (d) the existence of a relationship between the provider and the recipient, (e) support not given from or to an organization, the community, or a professional, and (f) support that does not have a negative intent or is given grudgingly.

Social support manifestations seemed predominantly superficial and did not appear to involve complex reciprocal relationships, however, when reciprocal resident tasks were observed, they appeared to have significant value and were sources of pride for the residents. Facility behaviors and policies required by governmental mandates appeared to result in significant resident dependency, a situation that mitigates against significant social support (Rash, 2007).

Due to the fast increase in the number of aged people in the world, the need for long term care services cannot be over-emphasized. This has more often than not implied jeopardizing the privacy of elderly as they move from their home in a familiar environment into an unfamiliar care institution setting (Schopp et al., 2003). As people age, they experience privacy loss due to health care needs, particularly in nursing homes. Consequently, balancing care giving of elders with respect for privacy boundaries represents a challenge to health care providers (Petronio & Kovach, 1997). In order to accept the care from others, elderly people have had to give up their privacy, especially as they have to move from their home

to a care unit, having to share a lot with other patients or residents. Previous studies on privacy confirm that female patients always feel more violation of their privacy than males, while elderly also perceived more violation than younger patients (Bauer, 1994).

On the part of the nurses and caregivers, it has been realized that those who are part time workers compared to those who are full-time workers have a positive attitude towards the maintenance of patients' privacy. Those who are better educated also have a faster way of responding to social pressure than the less educated. Most often people think of privacy only in terms of their bodies being exposed but the lack of privacy is related to handling of patient information, residents not being able to be alone when they feel the need to do so. There have been differences in the perceptions of privacy needs between patients and caregivers, as nurses seem to overestimate the needs of the patient and have also misjudged the patients' feelings and psychosocial needs (Mowinski and Muhlenkamp, 1981: 485-489). Finding a suitable balance where the care is given while taking into account the privacy of the patient, is usually not an easy task for the caregivers.

The privacy of patients has always been assessed with stereotypes by nurses (Farrell, 1991). Patients usually feel that their privacy is violated when nurses forget to close the door when the patient goes to use the lavatory or when their dignity is not respected when they are being assisted with personal hygiene. A reliable form of collaboration based on trust, respect, promptitude and high quality of elders nursing care has to be made between the nurses and the institutionalized patients, followed by a wide opening and effective communication with their families or relatives (Ngwane, 2011). Elderly nursing home residents also feel that they should be spoken to in a friendly manner and not treated as objects but rather as friends to the nurses. More often than not, the residents feel that things should be done according to their will and not to the wishes of the nurses and they should not be subjected to any form of routine without their consent (Ngwane, 2011). Older people have identified social relationships and social contacts with family and friends as important influences upon their quality of life (Bowling, 1995; Farquhar, 1995) and peer relationships are perceived as vitally important in the ageing process (Jerrome, 1992).

Investigations that quantify social interaction in institutional care settings have shown that residents do nothing for many hours, the findings of quantitative research consistently report that institutional care settings are bereft of high levels of social interaction and social activity (Bowie & Mountain, 1993; Godlove, Richard & Rodwell, 1982; MacDonald, Craig & Warner, 1985; McCormack & Whitehead, 1981; Mattiasson & Andersson, 1997; Nolan & Grant, 1995; VanHaitsma *et al.*, 1997; Ward et al., 1992. Moreover, much of the residents time is spent in social and emotional isolation (McKee, Harrison & Lee, 1999). This does not mean, however, that some residents do not socially interact on occasions. Qualitative research has shown that social relationships between residents are often

reciprocal and caring, although some may be hostile and unfriendly (Powers, 1991; Powers, 1996; Reed & Payton, 1997; Williams & Roberts, 1995). The most popular activity among the elder residents is talking, and the most common conversations centre on their feelings about living in the facility (Gutheil, 1991).

Institutional care settings may thus be described as places where residents spend most of their time in social isolation, but they may also be characterised as domains with pockets of social interaction between the residents. The development of social relationships among residents in institutional care settings is likely to vary both within and between care facilities. Various factors that influence both the quantity and quality of interaction between residents have been identified. These include: personal attributes such as hearing, speech, sight, ambulate and cognitive abilities (Bitzan & Kruzich, 1990; Retsinas & Garrity, 1985; Mor *et al.*, 1995; Kovach & Robinson, 1996).; structural attributes such as staffing levels and the physical environment (Moore, 1999); and cultural attributes such as the philosophy of care and perceptions of older age (Noelker & Poulshock, 1984; Reed & McMillan, 1995; Timko & Moos, 1990). Institutionalized elderly should interact one with the other, to initiate mental and physical activities to be involved. They must spend as much time together depending on their personal affinities. Mutual support of elderly people in various daily activities which they argue is an important psychosocial aspect of their lives. Closer collaboration with caregivers from nursing homes and continuous communication, as much as possible, with relatives or their families, is another important key in ensuring decent living conditions (Hubbard, Tester & Downs, 2003).

Methods

Purpose of research

The aim of this study is to find out the real life conditions of institutionalized elderly from three social care centers of Galati, the shortcomings and positive aspects of their existence, in order to design future measures to improve quality of elderly life in all aspects.

Objectives

The sample consisted of 195 elderly people admited in three nursing homes in Galati was studied by comparative analysis of elderly age, to discover the reasons why elderly persons was admitted in three retirement homes and about who have decided their institutionalization, the evaluation of the satisfaction degree of assisted persons in relation to living conditions in the social care centers, real health state analysis and finally, findings assisted by medical staff professionalism

and mutual assistance between institutionalized elderly. Any statistically differences between three groups were revealed.

Materials and Methods

The conducted study is retrospective and was carried out between 2002-2006 in three elderly care centers from Galati county: "Sf. Spiridon" retirement home (A), "Stefan cel Mare" social care center (B) and Medical-social center (C).

Participants

87 people of 140 hospitalized elderly from "Sf. Spiridon" retirement home were selected. This institution provides protection to old retired homeless people minimum 60 years aged without a family or legal support; they cannot support themselves and requires specialized social and health care; 50 elderly persons of 80 seniors in "Stefan cel Mare" social care center were selected for this study. In this institution, elderly with severe or medium disabilities are hospitalized, who have no income, homeless, without the possibility to support themselves or to live on their own. They requires specialized social and health institutional care; 3-rd institution included in this research is Medical-social center of Galati which includes 93 people with serious health problems which requires hospitalization, mentally ill adults respectively, 30-60 years aged or retired persons with other major health problems (Alzheimer's disease, oligophrenia, behavioral and memory disorders). From population of 93 people, about 53 of them were selected for this study *(Table 1)*. The working group included a total of 195 elderly people coming from three social care centers. The resulting sample is representative for aged population over 65 years in Galati (with a maximum error of + 5% at a 95% confidence interval) *(Table 1)*.

Table 1. *Sample composition of elderly persons in three nursing homes*

Nr. crt.	Institution	Abbreviation	The sampling base		The sample	
			Total number of elderly	%	Number of selected persons	%
1.	"Sf. Spiridon" retirement home	(A)	140	44,7	87	44,7
2.	"Stefan cel Mare" social care center	(B)	80	25,6	50	25,6
3.	Medical-social center	(C)	93	29,7	58	29,7
TOTAL			313	100	195	100

Instruments and procedures

In three medical welfare centers from Galati county, institutionalized aged people spend all their time and benefit of permanent accommodation, diversified meals (according to recommended dietary advice), medical care (healthcare, medicines and healing treatments) and social assistance (counseling, guidance, housekeeping). As working tools were used: individual questionnaire, training manual, sampling lists, summary tables: (1) *individual questionnaire* included several modules corresponding to objectives, dimensions and indicators established and also based invoice data: sex, age, marital status, education level, ethnicity, religion, employment state. The questionnaire had different types of questions (single or multiple response, open questions) and some questions that are based on different scaling methods: semantic differential Likert procedure, Stapel, rank ordering method, paired comparisons and constant-simple sum methods; (2) *training manual* contained details linked to the selection methods of interviewees, correct methods of completing the questionnaires; (3) *sampling lists* included selected interviewees after applying sampling methods established. These lists are introduced following information: name and surname of selected person, address, age, gender, codes, and some situations encountered during the interviews (refusals, lack of answers); (4) *summary tables* were compiled for each institution and cover data on the structure of the sample, the number of completed questionnaires, centralization of the situations encountered.

Entering data on the computer

The questionnaires were corrected before being used for the study. Data were entered in parallel by two teams and the results were overlapped, so entry errors were highlighted. Records inconsistencies were adjusted by checking the questionnaires. Specialized software was used for data entry: *SPSS Data Entry 4.0* (Boiculese, Dimitriu & Moscalu, 2007). Data analysis was performed using specialized software for statistical processing (SPSS 16). Database in SPSS format, which include all the items of questionnaires was corrected and labeled (Boiculese *et al.*, 2007). Age of person is a continuous variable that can be studied and compared. Since there are three groups of people, ANOVA test was applied. Checking data equal variances assumption was done by *Levene test*. Fisher statistic value was calculated to interpret ANOVA, respectively χ^2 for categorical data sets type and the statistical significance "p" was determined (Boiculese *et al.*, 2007; Hochspringen & Laatz, 2007). Multiple comparisons of average age's differences were made by Bonferroni test (Bland & Altman, 1995). To evaluate admission reasons in these institutions and satisfaction degree of elderly people on personnel services, a series of determinations were made on the same samples and data was statistically processed by variance ANOVA analysis, which consisted of Fisher statistics and χ^2 test to compare the studied people samples (Boiculese *et al.*, 2007).

The elderly people health state was assessed using International Statistical Classification of Diseases and Related Health Problems, Revision 10, Australian Modification (NCCH 2002). Each disease has a specific diagnosis code made by letters and numbers marked into parentheses. Statistical processing was performed using Epi Info 3.3. software, by univariate analysis with descriptive statistical indicators and Student t-tests (for statistical significance between different environments) and χ^2 test Mantel- Haenszel variant, also Yates corrected version (for statistical significance between different frequencies) (Boiculese *et al.*, 2007; Hochspringen & Laatz, 2007).

Results and Discussion

Characterization of the study group in age terms

It was applied statistical method of confidence intervals test (for 95% probability). If intervals overlap for different samples, there are no differences statistically significant. As a result of obtained data analysis, it can be observed that elderly coming from "Sf. Spiridon" retirement home are different in terms of age, in comparison with the elders from other two social care centers. It was verified the veracity of this difference by ANOVA test, because age can be considered as continuously variable type. Homogeneity of variances (standard deviations) was checked by *Levene* statistics (*Table 2*).

Table 2. *Homogeneity of variances check test*

Levene statistics	degrees of freedom 1	degrees of freedom 2	statistical significance (p)
0.411	2	192	0.664

Significance level p = 0.664 is much higher than 0.05 value, wich allows to accept equality of variances. Therefore, ANOVA test can be applied and conclusion found will be relevant.

Table 3. *Statistical significance of differences - ANOVA test*

Differences	Squares sum	Degrees of freedom	Squares average	F	Statistical significance (p)
between groups	2235.055	2	1117.528	12.389	0.000
into the group	17318.740	192	90.202		
Total	19553.795	194			

F = a ratio of two different measure of variance for the data

From Fisher's (ANOVA) test shown in *Table 3* it results that among institutionalized elderly in three retirement homes p 0.001 values was determined, so the existence of high statistical significance is obviously clear, something which was expected according to the interpretation ranges of variation (95%).
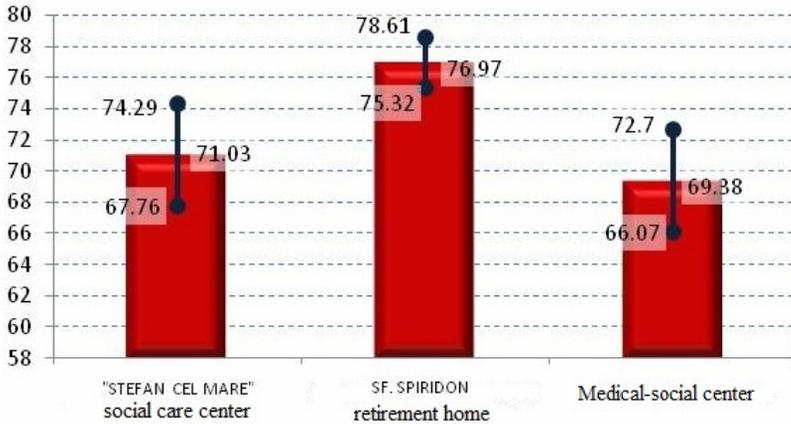

Fig. 1. *Average of age and confidence interval (probability of 95%)*

Table 4. *Comparing average differences*

Multiple comparisons : Bonferroni test						
unit (I)	unit (J)	average differences (I-J)	standard error	statistical significance (p)	95% confidence interval	
					lower limit	upper limit
"Stefan cel Mare" social care center	"Sf. Spiridon" retirement home (A)	-5.938 (*)	1.793	0.003	-10.27	-1.61
	Medical-social center (C)	1.646	2.141	1.000	-3.53	6.82
"Sf. Spiridon" retirement home	"Stefan cel Mare" social care center (B)	5.938 (*)	1.793	0.003	1.61	10.27
	Medical-social center (C)	7.585 (*)	1.710	0.000	3.45	11.72
Medical-social center	"Stefan cel Mare" social care center (B)	-1.646	2.141	1.000	-6.82	3.53
	"Sf. Spiridon" retirement home (A)	-7.585 (*)	1.710	0.000	-11.72	-3.45
* The average difference is significant at the 0.05 level						

Comparing average of two studied groups highlights retirement homes which are statistically different with respect to the assisted age, appearance illustrated in *Figure 1* and shown in *Table 4*. After *Figure 1* and *Table 3* analysis, we can say that elderly coming from "Sf. Spiridon" retirement home have higher age average than the elders from the two studied social care centers.

It can be seen that elderly people with highest age average (up to 75 years old) from "Sf. Spiridon" center prevails, followed by " Stefan cel Mare" social care center where elderly live with age average up to 67 years old and Medical-social center with people aged up to 66 years old. The reasons of elderly hospitalization in studied institutions. The reasons why people in the study group came in institutions are presented in *Table 5* and are one of the questions in the questionnaire.

Table 5. *The main reasons for elderly admission in three retirement homes*

Summary statistics						
	cases					
	valid		missing		Total	
	N*	%	N*	%	N*	%
What was the main reason you came to this retirement home ?	194	99.5%	1	0.5%	195	100%

N* = number of studied persons

What was the main reason you came to this retirement home ?							
		events	loneliness	homeless	insufficient home space	other	Total
		unit name					
unit	"Sf. Spiridon" retirement home (A)	cases	57	32	18	8	115
		%	49.6%	27.8%	15.7%	7.0%	100.0%
	"Stefan cel Mare" social care center (B)	cases	16	15	6	0	37
		%	43.2%	40.5%	16.2%	0.0%	100.0%
	Medical-social center (C)	cases	16	8	11	7	42
		%	38.1%	19.0%	26.2%	16.7%	100.0%
Total		cases	89	55	35	15	194
		%	45.9%	28.4%	18.0%	7.7%	100.0%

Chi square test			
	Value	Degree of freedom	Statistical significance (p)
Pearson chi square statistics	13.449 (a)	6	0.036
Number of valid instances	194		
2 cells (16.7%) have expected count less than 5. The minimum expected count is 2.86.			

Loneliness was the main cause, accounting for a share of 49.6% among the elderly in the "Sf. Spiridon" retirement home (A), 43.2% for those in "Stefan cel Mare" social care center (B) and 38.1% for the elderly from Medical-social center (C). Lack of housing is another admission reason for 40.5% of "Stefan cel Mare" social care center assisted 27.8% elderly of "Sf. Spiridon" retirement home and for 19% persons from Medical-social center. Iinsufficient storage house space was also a reason to leave the family in case of following elderly percentages: 26.2% of elderly from Medical-social center, 16.2% and 15.7% represents those coming from "Stefan cel Mare" social care center and "Sf. Spiridon" retirement home. Other reasons for leaving home are found to people from Medical-social center in a higher percentage (16.7%) and a lower percentage for elderly institutionalized in "Sf. Spiridon" retirement home (7%); the differences are statistically significant ($p < 0.05$, $p = 0.036$).

"Who have decided elderly admission to retirement homes?" is another question of individual questionnaire. Elderly answers are presented in *Table 6*.

Table 6. *Who have decided elderly admission to retirement homes?*

Summary statistics							
		cases					
		valid		missing		Total	
		N*	%	N*	%	N*	%
Unit * Did someone asked your opinion when you was admited ?		195	100 %	0	0.0 %	195	100%

N* = number of studied persons

Did someone asked your opinion when you was admitted ?							Total
	unit name	events	I decided myself	I was not asked for my opinion	I was asked for my opinion	I do not remember	
unit	"Sf. Spiridon" retirement home (A)	cases	99	3	9	5	116
		%	85.3%	2.6%	7.8%	4.3%	100.0%
	"Stefan cel Mare" social care center (B)	cases	24	3	10	0	37
		%	64.9%	8.1%	27.0%	0.0%	100.0%
	Medical-social center (C)	cases	19	6	15	2	42
		%	45.2%	14.3%	35.7%	4.8%	100.0%
Total		cases	142	12	34	7	195
		%	72.8%	6.2%	17.4%	3.6%	100.0%

Chi square test			
	Value	Degree of freedom	Statistical significance (p)
Pearson chi square statistics	32.237(a)	6	0.0
Number of valid instances	195		
5 cells (41.7%) have expected count less than 5. The minimum expected count is 1.33.			

The percentage of people who were asked about their opinion is 7.8% elderly from "Sf. Spiridon" retirement home, 27% from "Stefan cel Mare" social care center and 35.7% for Medical-social center *(Table 6)*. Examined group includes also people who did not come by their own will: 14.3% from Medical-social center, 8.1 % elders coming from "Stefan cel Mare" social care center and 2.6% people from "Sf. Spiridon" retirement home. People who do not remember if their consent were required are: 4.8% elderly from Medical-social center and 4.3% coming from "Sf. Spiridon" retirement home. Differences between elderly comings from three retirement homes have a high statistical significance (p < 0,001). *Table 6* highlights the highest elderly percentage who came on their own will into social care centers A, B, C is 85.3%, 64.9% and 45.2% respectively.

The next question in the questionnaire refers to the satisfaction degree of the elderly to living conditions in three studied institutions (*Table 7*).

Table 7. *Satisfaction degree of assisted persons in relation to living conditions in the social care centers*

Summary statistics						
	cases					
	valid		missing		Total	
	N*	%	N*	%	N*	%
Unit * How satisfied are you overall with the way you live?	191	97.9%	4	2.1 %	195	100%

N* = number of studied persons

How satisfied are you overall with the way you live?							
	unit name	events	Very dissatisfied	dissatisfied	satisfied	Very satisfied	Total
unit	"Sf. Spiridon" retirement home (A)	cases	5	23	60	26	114
		%	4.4%	20.2%	52.6%	22.8%	100.0%
	"Stefan cel Mare" social care center (B)	cases	0	10	19	7	36
		%	0.0%	27.8%	52.8%	19.4%	100.0%
	Medical-social center (C)	cases	1	9	21	10	41
		%	2.4%	22.0%	51.2%	24.4%	100.0%
	Total	cases	6	42	100	43	191
		%	3.1 %	22.00%	52.40%	22.50%	100.0%

Chi square test			
	Value	Degree of freedom	Statistical significance (p)
Pearson chi square statistics	2.709 (a)	6	0.844
Number of valid instances	191		
3 cells (25.0 %) have expected count less than 5. The minimum expected count is 1.13.			

As shown in *Table 7*, the percentage of people who are satisfied about living conditions is 52.6% for elders coming from "Sf. Spiridon" retirement home, which is similar to those of "Stefan cel Mare" social care center (52.8%). Satisfied people about living conditions are in percentage over 50% (51.2%) in Medical-social center and also increase the number of very satisfied persons (24.4%) coming from this social care center, compared to other two studied retirement homes. The percentage of very satisfied people (22.8%) from "Sf. Spiridon" retirement home is slightly higher than the elderly living in Stefan cel Mare" social care center (19.4%). People are dissatisfied about living conditions in proportion of 20.2% for those living in Sf. Spiridon" retirement home, 27.8% elderly coming from "Stefan cel Mare" social care center and 22% people from Medical-social center. At the opposite side are those who are very dissatisfied about living conditions: 4.4% elderly from "Sf. Spiridon" retirement home and 2.4% coming from Medical-social center. The differences found are not statistically significant ($p = 0.844$). Elderly opinions about medical staff employed professionalism from these institutions were deduced from a question contained in questionnaire which is related in *Table 8*.

Table 8. *Findings assisted by medical staff professionalism*

To what extent your complaints about colleagues or staff of the home are related to medical staff professionalism ?							Total
unit	unit name	events	very little	little	largely	heavily	
	"Sf. Spiridon" retirement home (A)	cases	63	12	10	5	90
		%	70.0%	13.3%	11.1%	5.6%	100.0%
	"Stefan cel Mare" social care center (B)	cases	12	6	7	3	28
		%	42.9%	21.4%	25.0%	10.7%	100.0%
	Medical-social center (C)	cases	9	10	5	9	33
		%	27.3%	30.3%	15.2%	27.3%	100.0%
Total		cases	84	28	22	17	151
		%	55.6%	18.5%	14.6%	11.3%	100.0%

Chi square test			
	Value	Degree of freedom	Statistical significance (p)
Pearson chi square statistics	25.798 (a)	6	0.0
Number of valid instances	151		
4 cells (33.3 %) have expected count less than 5. The minimum expected count is 3.15.			

Table 8 reveals that assisted persons coming from Sf. Spiridon" retirement home represents the highest percentage of little and very little unsatisfied people, totaling 83.3%. On second place are located elderly from "Stefan cel Mare" social care center with 64.3% people that assets the same way medical professionalism and on the last place are persons institutionalized in Medical-social center with 57.6% positive feedbacks. Unsatisfied and very unsatisfied people are found, in highest proportion, especially in Medical-social center (42.5%). On next place are situated the assisted persons from "Stefan cel Mare" social care center (35.7%) and the last position is occupied by "Sf. Spiridon" retirement home assisted (16.7%). By comparing the results (chi square test), is found that the differences between elderly samples from three institutions are high statistically significant (p < 0.001).

Mutual assistance is an important aspect, which indicates directly human relationships. This is related in *Table 9*.

Table 9. *Findings by elderly mutual assistance*

Summary statistics						
	cases					
	valid		missing		Total	
	N*	%	N*	%	N*	%
Unit * Do you help your colleagues in various issues of supply, dressing, eating, drugs administration ?	184	94.4%	11	5.6%	195	100.0%

N* = number of studied persons

	Do you help your colleagues in various issues of supply, dressing, eating, drugs administration ?					Total
	unit name	events	rarely/never	rarely	frequently	often	
unit	"Sf. Spiridon" retirement home (A)	cases	65	14	26	4	109
		%	59.6%	12.8%	23.9%	3.7%	100.0%
	"Stefan cel Mare" social care center (B)	cases	17	11	7	1	36
		%	47.2%	30.6%	19.4%	2.8%	100.0%
	Medical-social center (C)	cases	20	10	6	3	39
		%	51.3%	25.6%	15.4%	7.7%	100.0%
Total		cases	102	35	39	8	184
		%	55.4%	19 %	21.20%	4.31%	100.0%

Chi square test			
	Value	Degree of freedom	Statistical significance (p)
Pearson chi square statistics	8.868(a)	6	0.181
Number of valid instances	184		
3 cells (25.0 %) have expected count less than 5. The minimum expected count is 1.57.			

High percentage of assisted persons which rarely help or do not help at all each other on supplying, dressing, feeding, and drugs administration. Most of them are located in "Sf. Spiridon" retirement home (59.6% of the elderly) and Medical-social center (51.3% assisted). A lower percentage is encountered between elderly comings from "Stefan cel Mare" social care center (47.2% of institutionalized people). About 23.9% persons coming from "Sf. Spiridon" retirement home frequently help each other, followed by Stefan cel Mare" social care center with 19.4% elderly and Medical-social center comprising 15.4% elderly who help each other. The differences between elderly from three institutions are not statistically significant (p = 0.181).

Health state characterization of the elderly institutionalized in three care centers

In "Sf. *Spiridon" retirement home* most of the assisted persons are affected by cardiovascular diseases (I00-99), at a rate of 70.87%, osteo-articular diseases (M00-99) 37.80%, digestive diseases (K00-93) 29.92%, nervous system diseases (G00-99) 23.62%, mental and behavioral disorders (F00-99) 15.75%, endocrine nutrition diseases and metabolism disorders (E00-89) 14.96%. There are recorded also low frequency pathologies like respiratory diseases (J00-J99) 11.02 %, kidney diseases in percentage of 7.87%, diseases of the eye and its appendages (H00-59) 7.09% and infectious diseases (A00-B99) in 3.94% proportion of the institutionalized elderly.

"Stefan cel Mare" social care center includes assisted elders which are affected by neurological disorders (G00-99) 42%, osteo-articular diseases (M00-99) 30%, cardiovascular diseases (I00-99) 20%, A percentage about 16% of them are affected by diseases of the eye and its appendages (H00-59), also endocrine nutrition diseases and metabolism disorders (E00-89). About 10% of them are suffering from mental and behavioral disorders (F00-99), respiratory diseases (J00-J99) 6% of institutionalized people and infectious diseases (A00-B99) about 2% of the elderly.

In Medical-social center of Galati, most of the people are affected by: (1) cardiovascular diseases (I00-99) 58,46%, represented by essential hypertension (HTA) stage II with very high risk, chronic ischemic heart disease, chronic venous insufficiency, congestive heart failure NYHA class II; (2) behavioral and mental disorders (F00-99) 53,85%, represented by anxious-depressive disorder, organic personality disorder with involutive background, Alzheimer's disease, Parkinson's disease, obsessive-phobic psychopathy elements; (3) nervous system diseases (G00-99) assigned to 43.08% of assisted persons, such as multiple lacunar infarctions sequelae (AVC) with hemiparesis, toxic-carential polyneuropathy, subacute subdural hematoma of the right hemisphere, diffuse cortical atrophy; (4) endocrine nutrition diseases and metabolism disorders (E00-89) for 21.54% of elderly, such

as type 2 diabetes treated with oral medication, dyslipidemia, obesity of II degree (Mass Corporal index, IMC 30.7), osteoporosis, type 2 diabetes insulin-dependent; (5) osteo-articular diseases (M00-99) 21.54% , such as cervico-thoraco-lumbar spondylo-discartrose, bilateral osteoarthritis, progressive muscular dystrophy, pressure sores, fractures (femoral neck, sub-trochanteric); (6) eye and its appendages diseases (H00-59) assigned to 10.77% of elderly, such as chronic glaucoma, mature cataract, conjunctivitis; (7) respiratory diseases (J00-99) in 10.77% percentage, like chronic obstructive pulmonary bronchitis (BPOC) with numerous acute episodes, mixed asthma, bilateral basal pleuritis.

It follows, in lower percentages, digestive diseases (9.23%), such as atrophic gastritis, viral ethilogy cirrhosis vascular and parenchymal decompensated, chole-lithiasis, chronic constipation. In the same category are situated also diseases of the blood, infectious diseases, kidney diseases (3.08%), lower urinary tract infections accompanied by several relapses with E-coli resistant to a lot of antibiotic classes, kidney lithiasis, chronic kidney failure with fixed nitrogen retention state and the tumors (1.54%).

Conclusions

According to this study, was noted that elderly coming from "Sf. Spiridon "retirement home (A) includes people with highest age average than the other two social care centers from Galati county (this difference is high statistically significant, p < 0.001) . In this nursing home, the most common age group represents 75-84 years old people, when the assistance necessity is greater due to permanent loss of independence, to physical health damage, caused by loneliness.

The main causes which have led elderly to resort to institutionalization were the following: loneliness for 45.9% of the examined group, homelessness for 28.4%, insufficient house space assigned to 18% of elderly. Loneliness recorded the highest percentage of elderly in "Sf. Spiridon "retirement home (A) 49.6%, homelessness presented the highest percentage between people from "Stefan cel Mare" social care center (B) 40.5% and insufficient home space was found frequently between people of Medical-social center (C) , about 26.2%. The differences can not be considered statistically significant although p 0.001, due to insufficient cases frequency (0.38).

People in the study group have used this care opportunity by their own initiative (72.8%). About 17.4% people from the group were consulted by those who have institutionalized them, 6.2% where not asked about their opinion and the last category is represented by those who do not remember (3.6%). Elderly from "Sf. Spiridon "retirement home who came on their own initiative prevails (85.3%), followed by "Stefan cel Mare" social care center and Medical-social center with

64.9% and 45.2% of elder persons. Elderly which were consulted by those who have institutionalized them, elders whom no opinion was requested and persons who do not remember was found in the highest percentage in Medical-social center (35.7%, 14.3% and 4.8%). Differences between three elderly samples have a high statistical significance (p 0,001).

Regarding the satisfaction degree of elders on living conditions, it was found that most of them are satisfied about that (52.40%). On the first place were situated the elderly people from "Stefan cel Mare" social care center (52.80%) At a very small difference it was followed by "Sf. Spiridon" retirement home elders (52.60%) and on the last place was the elders coming from medical-social center (51.2%). Those people who were very satisfied about living conditions of three institutions were in percentage of 22.50% (24.4% elders from Medical-social center, 22.8% from Sf. Spiridon "retirement home and 19.4% people coming from "Stefan cel Mare" social care center).The percentage of dissatisfied persons from the study group was about 22.0%. Most of them are found in "Stefan cel Mare" social care center (27.8%) followed by Medical-social center (22.0%) and "Sf. Spiridon" retirement home (20.2%). The differences found between three samples are not statistically significant (p = 0.844).

Most of the assisted elderly (55.6%) had complaints about medical staff professionalism in a very small extent. Their condition is very good. Among the less dissatisfied were the elders of Sf. Spiridon" retirement home (70% of elderly), "Stefan cel Mare" social care center (42.9%) and on the last place 27.3%. of elders from Medical-social center were found. At the opposite pole were placed the elders which were very dissatisfied about medical staff professional competence (11.3% of the studied group).The most dissatisfied of this category were elderly people from Medical-social center (27.3%), followed by "Stefan cel Mare" social care center (10.7%) and Sf. Spiridon" retirement home (5.6% of elders).

Relating to mutual assistance, 55.4% of elderly studied group has rarely or never helped their colleagues in various issues of supply, dressing, eating, drugs administration, which is a negative aspect. Most of them belong to "Sf. Spiridon" retirement home (59.6%). On second place are situated elderly persons coming from Medical-social center (51.3%) and the last place is occupied by "Stefan cel Mare" social care center (47.2% of elders). Most of the assisted persons argued that they would prefer to be admitted in an institution which can provide specialized complete care.

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