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Quality of life in long-term care facilities in Gauteng, South Africa: an institutional ethnographic study of older adults' perspectives

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ABSTRACT

Introduction The increasing demand for long-term care (LTC) services in resource-constrained settings has highlighted significant gaps in both the quality of care and the quality of life (QoL) for older adults. The objective of this study is to examine the lived experiences of QoL among older individuals in LTC facilities.

Methods Using an institutional ethnographic approach, we conducted indepth interviews with 20 residents, aged 62–98 years, across five LTC facilities in Gauteng, South Africa. Indexing and mapping were used to identify emergent categories. The authors used reflexive methods, and member checking was conducted.

Results Analysis revealed seven interconnected dimensions of QoL: health and physical well-being, social connectedness and companionship, spiritual fulfilment and faith, independence and autonomy, dignity and respect, emotional well-being and acceptance and adaptation. These aspects are closely linked to institutional factors such as staff capacity, resource allocation and care policies. Participants emphasised the importance of meaningful social interactions, spiritual practices, autonomy and dignity in enhancing their QoL.

Conclusion The study underscores the complex relationship between institutional care practices and the QoL of older adults in resource-constrained environments. Findings advocate for culturally sensitive, person-centred care strategies to improve the multifaceted QoL of LTC residents, offering valuable insights for policy reforms and interventions in similar resource-constrained settings.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ The study employed institutional ethnography which provided an indepth understanding of how institutional structures shape the quality of life of older adults in long-term care facilities.
⇒ Findings may be context-specific, limiting generalisability. Comparative studies in diverse settings could provide broader insights.
⇒ The use of multiple data collection methods, including interviews, observations and document reviews, enhanced the credibility and validity of the findings.
⇒ The institutional ethnography approach is resource-intensive and time-intensive, which may limit scalability; a phased research design could help address this limitation.
⇒ The complexity of data analysis required substantial reflexivity and expertise, but the use of a reflexive journal helped document biases and enhance research transparency.

INTRODUCTION

The global increase in the geriatric population presents a growing demand for long-term care (LTC) services, especially in resource-constrained settings. South Africa mirrors this trend, with its older population increasing from 3.3 million in 2002 to 5.7 million in 2022, with projections suggesting further growth to 163 million by 2050 across Sub-Saharan Africa.[1 2] This demographic shift underscores the urgent need for effective LTC systems to address the care and quality of life (QoL) of older adults.[3 4] However, various difficulties exist in Sub-Saharan Africa, with 36 of the 46 Sub-Saharan African countries earmarked as having critical human health resources deficiencies, such as a shortage and unsatisfactory distribution of health workers.[5] Thus, compared with other countries internationally, the majority of countries in Sub-Saharan Africa reflect a dismal picture of formal LTC for older people. In addition, the traditional culture of black Africans embraces the provision of care within the family context and not in institutionalised circumstances.[6] Nevertheless, there is a gradual shift towards governmental care in LTC facilities due to poverty, a lack of suitable accommodation for older people and an inability of extended families to provide care for their elderly.[7 8] Despite the growing demand, many resource-constrained countries lack well-developed LTC systems which focus on enhancing QoL for older adults.[9 10]

LTC system should improve the functional status and QoL of older people as much as possible.[11] QoL is defined differently across

disciplines because of the cultural, ethical, religious and personal aspects that influence it. It includes structures such as dignity, satisfaction, social participation, autonomy and happiness. Despite differences in definitions, most authors agree that if one wants to assess QoL, a multidimensional approach must be considered.[12–14] There is a close relation between older people and their environment and its impact not only on their health status but QoL.[15] Studies conducted on QoL among older people show that when older people can live and receive support in their preferred care location, they report a better QoL.[16] However, those living in LTC facilities have been associated with poorer well-being and QoL.[17] The WHO defines QoL as an individual's perception of their position in life within the context of the cultural value systems they inhabit and in relation to their goals, expectations, standards and concerns. This broad concept encompasses dimensions such as physical health, psychological well-being, level of independence, social relationships, personal beliefs and one's interaction with their surrounding environment.[18] In evaluating QoL, scholars have identified multiple domains—physical and material well-being, interpersonal relationships, social and civic engagement, personal growth, fulfilment and leisure—which have informed the development of QoL measurement tools.[19 20] A common thread across these tools is the recognition of social and environmental factors as central to QoL. Recent research involving older adults living in communities in South Africa and Uganda found that limitations in performing activities of daily living negatively affected both health and QoL.[21] Similarly, studies focusing on older adults in institutional care settings have shown that a lack of autonomy and limited opportunities to engage in meaningful activities—whether communal or personal—are associated with diminished QoL.[22 23]

While regulatory frameworks emphasise person-centred care as a key strategy for improving QoL in LTC,[24] barriers remain, particularly in resource-constrained settings, where institutional challenges limit effective implementation.[25] Existing research often overlooks the perspectives of older adults in defining QoL,[26 27] yet understanding their views is essential for the design of interventions and provision of formalised person-centred care.

This study focuses on government-subsidised LTC facilities in the Tshwane District in the Gauteng Province of South Africa, aiming to explore the ways in which older adults perceive QoL and how institutional structures shape their lived experiences. The study provides critical insights into LTC policy and practice in low-resource settings, where approaches to person-centred care remain underdeveloped.

METHODS

Study design: institutional ethnographic approach

We adopted Smith's institutional ethnography (IE) to explore LTC institutions from the perspective of older adults, a structurally marginalised and disempowered group. This approach aims to understand how institutional powers shape and govern people's local social environments, knowledge, practices and activities, while also examining work processes and how they are coordinated.[28] For this study, IE was adopted not only to explicate how institutional powers organise QoL of older people but also to investigate the relationship between QoL and organisational structures beyond power dynamics. IE research begins with everyday life experiences, linking these experiences to broader social relations within the institutional context.[29] Data were collected through observations, informant interviews and a review of institutional documents; however, this paper focuses solely on data obtained from key informant interviews with older adults, aimed at understanding their perception of QoL.

This study forms part of a larger project conducted by the lead author (NH) under the supervision of the second author (LN). The research was inspired by NH's professional experience as an occupational therapist in LTC settings and personal exposure to LTC through a family member, which highlighted disparities between ideal QoL outcomes and lived experiences.

South African context

In South Africa, LTC facilities are classified based on funding, regulatory oversight and the level of care provided. These include government-subsidised facilities, which receive partial state funding and cater to financially disadvantaged older adults; private facilities, which operate independently and vary in cost and quality; non-profit or faith-based facilities run by NGOs or religious organisations; public frail care units within hospitals that provide intensive medical care; and home-based or community care programmes that support ageing in place. LTC services range from independent living for older adults who require minimal assistance to assisted living facilities that provide support with daily activities. Frail care units offer 24-hour nursing for individuals with severe physical or cognitive impairments, while palliative and end-of-life care focuses on comfort for those with terminal illnesses. Additionally, respite care services provide short-term relief for primary caregivers.[30] Historically, most LTC facilities primarily served white older adults.[31] Despite postapartheid reforms, many facilities remain concentrated in urban areas and predominantly serve white populations.[32] The focus of this study is on LTC facilities in resource-constrained contexts, these environments being characterised by a lack of economic, social and human resources or infrastructures. South Africa is deemed a resource-constrained country in Sub-Saharan Africa.[33]

Study setting

Eight government-subsidised LTC facilities, registered with the Department of Social Development (DSD) and located in a periurban community in the Tshwane District of Gauteng Province, South Africa, were approached for this study. These facilities were selected due to their

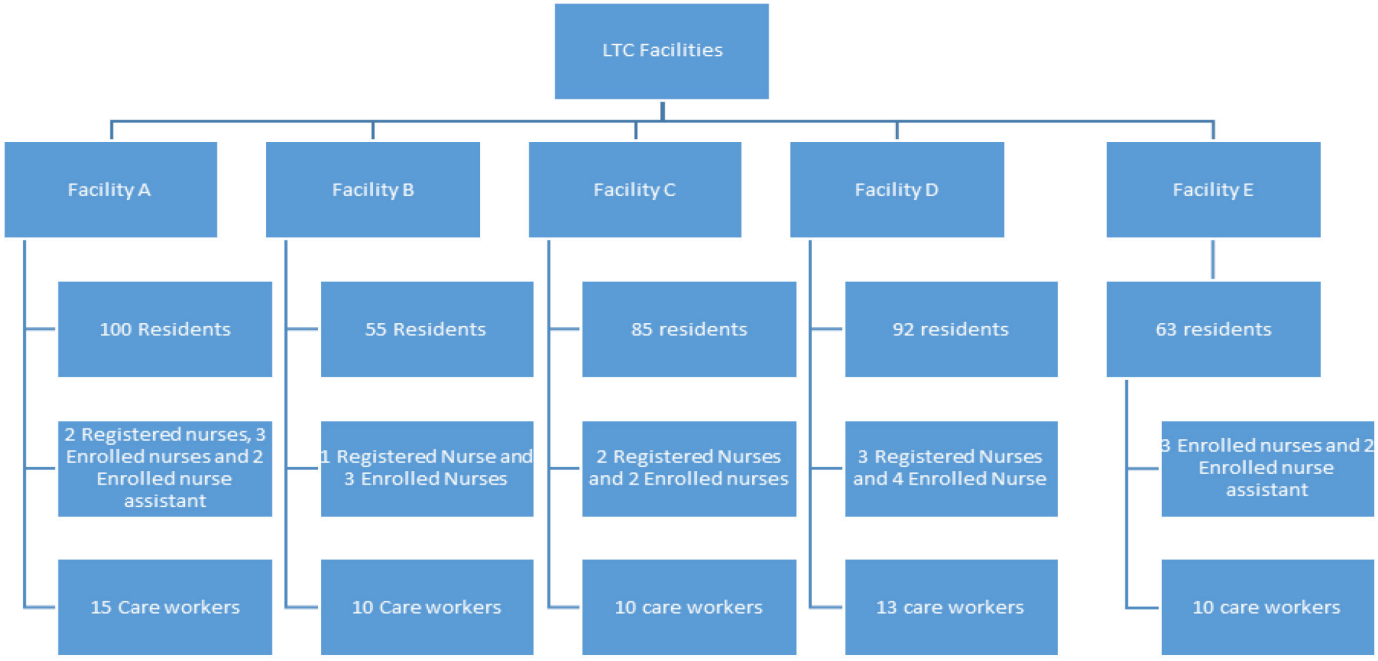

Figure 1 Facility Staffing. LTC, long-term care.

reliance on government subsidies, which reflects the broader issue of affordability for many older persons seeking LTC services. All selected facilities adhered to care provision regulations outlined by the Regulations regarding Older Persons, which categorise residents based on their level of care needs: category 1: independent residents who do not require assistance with daily activities such as eating, bathing, personal hygiene, using the toilet or mobility; category 2: residents requiring assisted living, with support provided for daily tasks; category 3: frail residents who are fully dependent and require 24-hour care due to severe physical or mental health conditions preventing self-care.[34]

The selected facilities on average housed between 50 and 100 residents, with accommodations arranged according to categories of care required. Staffing at these facilities on average included a facility manager with other administrative staff, two to three nurses varying in qualification and 10 care workers figure 1.

Sampling and recruitment

Fieldwork was conducted from February–September 2023 following ethical approval from the Stellenbosch University Health Research Ethics Committee (reference number: S22/06/105) and institutional permission from the DSD, which registers and governs LTC facilities. IE research does not prescribe a specific number of informants, the focus being on gathering a sufficient range of participants to capture diverse experiences within the institution and uncovering ruling discourses across various contexts.[35] To ensure effective resource allocation and inclusion of a broad spectrum of experiences, eight LTC facilities were purposively selected and invited to participate in the study. Of these, five agreed to participate. The three facilities that declined to participate cited resource constraints as their primary concern. Specifically, they indicated that they were under-resourced and lacked the capacity to allocate staff time for research activities. Additionally, they expressed concerns about maintaining the privacy of residents during the study. These factors ultimately influenced their decision not to participate. From the five facilities, we recruited 20 older people as standpoint informants—a central concept in IE methodology. These informants were predominantly older black individuals, with the majority being female (12 women and 8 men), aged between 62 years and 98 years. The majority were of a Christian religious background, with the disease profile across informants including hypertension, diabetes and arthritis. Most participants had resided in their respective facilities for extended periods, with lengths of stay ranging from 6 months to 7 years, ensuring a diverse range of lived experiences. Informed written consent was obtained for all observations, interviews and audio recordings, and participants were assured that their contributions would be anonymised.

Data collection

Interviews were conducted by NH, who used an iterative approach typical of IE research. Consistent with IE methodology, interview questions were adapted based on emerging insights, and follow-up interviews were conducted where necessary.[36] Informants were treated as experts in their daily lives, and interviews aimed to uncover the meaning of QoL and the way in which this meaning could be shaped by institutional practices.[37] An interview guide was developed using insights from the literature and preliminary observations. Interview questions focused on several key dimensions of QoL, including: physical well-being, social relationships and interactions, emotional well-being, autonomy and decision-making,

safety and security, and recommendations for improving QoL. The questions were open-ended and thus designed to explore informants' understanding of QoL, such as: 'what does QoL mean to you?' and 'could you describe a typical day?'. Follow-up questions sought to clarify observations or the use of institutional documents, for example: 'I saw you doing this during leisure time; can you tell me what was going on?' Probes were used to encourage informants to elaborate further on their experiences and perspectives. Interviews were conducted inperson in a private room within the LTC facilities, lasting between 60 min and 90 min. All interviews were audio-recorded, transcribed verbatim and translated from Setswana into English according to the resident's preference. To maintain confidentiality, transcripts were anonymised, and data were securely stored using Dedoose software. Field notes taken during and after the interviews supplemented the transcripts. This iterative approach allowed NH to continuously refine her understanding of how informants' QoL was constructed. By emphasising informants' standpoints and integrating their lived experiences, this approach provided a rich, nuanced understanding of how institutional practices shape QoL in LTC settings.

Data analysis

Data collection and analysis were conducted concurrently, following Campbell and Gregor's[28] IE framework. Analysis involved iterative reading of interview transcripts, identifying patterns and linking these to institutional processes. These transcripts were imported into Dedoose, a qualitative data analysis software, the memo function of which NH used to annotate key terms and concepts and organise data, employing indexing (see table 1 below).[38] Emerging links were categorised, and relevant quotes were indexed under folders such as 'health' and 'social relationships.' For example, health was a recurring category, with informants linking good health to positive QoL. We (NH and LN) analysed data by asking key questions: what does QoL mean to the informants? What institutional practices influence their QoL? This systematic approach enabled us to trace ruling relations and institutional discourses across different LTC settings.

Table 1 illustrates the indexing process used to analyse data in line with IE. Key concepts frequently mentioned by informants, such as 'autonomy,' 'privacy,' 'health' and 'social relationships,' were identified and organised into thematic folders. Each folder contains direct quotes and descriptions from interviews and documents that relate to these themes. The indexing process enabled systematic cross-referencing, allowing the research team (NH and LN) to link everyday experiences of older people to institutional practices and ruling relations. The table demonstrates how these thematic categories were developed iteratively as data collection progressed.

The systematic process of iterative analysis, namely, indexing, enabled us to trace the process whereby the meaning of QoL is socially organised by institutional traces. This approach offered a deeper understanding of the institutional contexts within which LTC residents' QoL is constructed.

Reflexivity

NH identifies as a black South African woman and an occupational therapist with over 7 years' experience working in diverse settings, including LTC facilities. Her professional background provided her with in-depth knowledge of the daily operations, health standards and norms essential to these environments. She augmented this insider knowledge by making use of a reflexive journal for notetaking during data collection and analysis, documenting her experience during data collection and noteworthy issues about the quality of each interview. LN interrogated this data and NH's findings to ensure that they were a true reflection of the data, to minimise NH's perceptions biasing the interpretations made.

Patient and public involvement

Stakeholders were first involved during the initial stages of the research process through consultations with older residents and staff in LTC facilities, this being to identify key issues affecting their QoL. The research questions and outcome measures were developed based on their lived experiences, priorities and preferences, ensuring relevance to their QoL. Participants were actively engaged in study design, recruitment and data collection by contributing feedback on interview topics and logistical considerations, and they will be further involved in disseminating results through presentations at community meetings and sharing user-friendly summaries tailored to their needs.

Table 1 Indexing process for institutional ethnographic analysis

Interview data	Institutional trace	Indexing
"So, the quality of life, eish, yeah, I don't know what I can say but I don't think; it's much lower than what it used to be. I don't see anything; I don't know anything. If only I had my own things. Yes, things that will teach me. Things that entertain. It doesn't mean that when you're old, you no longer need things to entertain you." (85-year-old woman residing in the facility for 7 years)	Older Persons Act and national norms and standards mandate that residents should participate in organised activities, including but not limited to reading, radio and TV and religious and cultural activities, thus promoting well-being.	Older people value their independence and the opportunity to engage in a variety of meaningful activities. While regulations require facilities to offer residents these opportunities, this is often not happening, as staff tend to prioritise care practices over facilitating engagement in activities.

Trustworthiness

This study ensured trustworthiness through prolonged engagement with informants, enabling an indepth understanding of the context and the lived experiences of older people in LTC facilities. Persistent observation, combined with multiple data sources—participant observations, interviews and document reviews—facilitated triangulation, enhancing the credibility of the findings. To support claims, we extracted and presented direct quotes from informants, consistent with the IE principle of ensuring confirmability by grounding interpretations in participants' material realities.

An audit trail was maintained throughout the research process. All collected data, including interview transcripts and field notes, were securely stored in a qualitative analysis software programme, ensuring dependability and transparency. Although generalisability is not a primary goal of IE studies, transferability was strengthened by describing and comparing ruling relations across five LTC facilities. This approach allowed us to identify patterns in how government policies, institutional management and caregiving practices influenced QoL.

In line with DeVault and McCoy (2002),[39] our analysis did not aim to generalise findings to a broader population, but aimed instead to reveal institutional practices that extend beyond the specific sites studied. By exploring the shared organisational processes that shaped residents' QoL, we provide insights into systemic challenges and opportunities relevant to LTC facilities in resource-constrained settings.[39]

RESULTS

Resident demographics

The study included 20 older residents from five LTC facilities, with ages ranging from 62 years to 98 years. The majority of participants were women, reflecting broader gender demographics typical of LTC settings. Most residents had spent significant time in the facilities, with lengths of stay varying from 6 months to 7 years.

In the following section, we present a critical analysis of the meaning of QoL under seven analytic threads, namely: (1) health and physical well-being, (2) social connectedness and companionship, (3) spiritual fulfilment and faith, (4) independence and autonomy, (5) dignity and respect, (6) emotional well-being and (7) acceptance and adaptation. In figure 2, we have included the various threads and organisational aspects that are interconnected with the older person's understanding of QoL. In the following section, we refer to older people as 'residents'.

Health and physical well-being

Residents associated QoL with improvements in their physical health after moving to the LTC facility. This included medication adherence and consistent access to healthcare. Physical comfort was also emphasised, with mention of access to blankets, laundry services and clean sheets, which promote a sense of dignity and care:

> There has been an improvement in my health since coming here because I drink my pills properly and I don't get sick too much. (Early 70-year-old residing in the facility for 3 years)

> Now that I am here, I am taken to the clinic with Mmanoma's car to go and see the doctor.… My eyes are way better now, I can almost see. (Mid-70-year-old residing in the facility for 5 years)

However, physical limitations and deteriorating health remained a concern, as some residents expressed fear of becoming dependent on wheelchairs or being unable

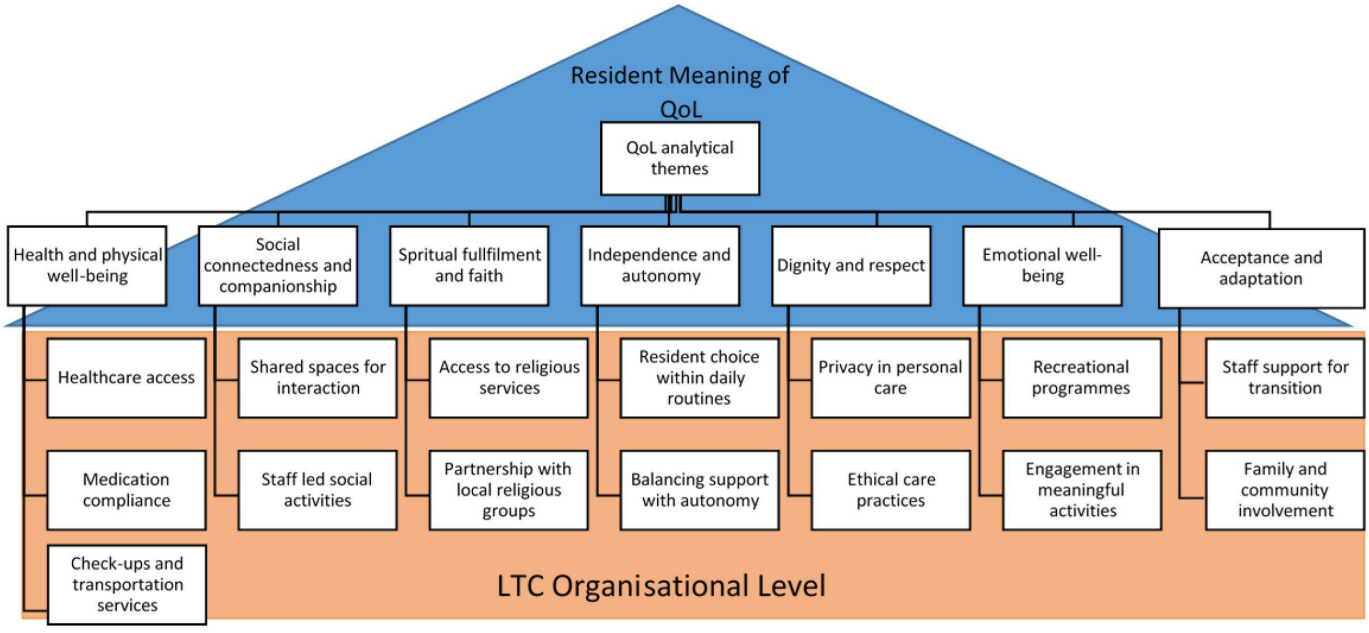

Figure 2 Social organisation of quality of life (QoL). LTC, long-term care.

to perform daily tasks. The desire to maintain physical independence was identified as being important to their well-being:

> It is ill health that makes me not do the things I want to do; I am unable to stand up properly. I am now fighting to stand up so that I don't use a wheelchair. (Early-70-year-old residing in the facility for 2 years)

Social connectedness and companionship

Residents found comfort and joy in the companionship offered by living with other residents. Daily interactions, shared conversations and group activities created a sense of community and alleviated the loneliness which they sometimes experienced at home.

Engaging in meaningful conversations, laughing together and group discussions provided social support, resulting in their feeling understood and connected, which they felt to be critical to their well-being:

> I feel completely fine and properly settled in since I'm with other people. And I become comforted when I see other people around me also comfortable, and that makes my heart be at ease. (Mid-70-year-old residing in the facility for 6 months)

> The thing that brought me happiness the most is the fact that when I arrived here, I arrived at a good place and I was satisfied. The people that I now live with are good, we have good conversations, and I feel happy. (Late 80-year-old residing in the facility for 1 year)

Interaction with others assisted in combatting loneliness and providing mental stimulation:

> Here we talk and laugh, we eat and drink tea.… When you are at home, children are at work during the day, and you stay at home.… Here, you are with people, and you can converse. (Mid-80-year-old residing in the facility for 7 years)

Spiritual fulfilment and faith

Faith and spirituality played a central role in providing emotional support and a sense of purpose. Many participants expressed a deep reliance on prayer, church services and pastoral visits, which brought them comfort and happiness. For some, faith was also a way of accepting their current situation, finding peace and coping with life's hardships. Prayer and religious gatherings became sources of inner peace, helping them to accept their situation and derive meaning from their daily lives:

> I solely let my life depend on prayer, and in God.… I think my life is alright because I've always believed in prayer and lived a prayerful life. (Mid-70-year-old residing in the facility for 6 months)

> What brings me happiness is church and praying.… When I say amen, I will feel this happiness as if the person I was talking to was here with me. (Mid-80-year-old residing in the facility for 7 years)

For many, accepting their circumstances and finding meaning in faith brought peace:

> I just tell myself that the place I'm in right now, I need to get used to it and it's my home and I've made peace with it so I'm at peace. (Early-60-year-old residing in the facility for 3 years)

Independence and autonomy

QoL for some residents was related to autonomy—the ability to make their own decisions and maintain control over their lives. There were expressions of dissatisfaction regarding the limitations imposed by the care setting, such as financial constraints and reliance on others for personal errands, which led to feelings of restriction. Some residents expressed a desire to be able to work or engage in activities that gave them a sense of accomplishment, reflecting the value they placed on independence and self-determination:

> A better life is when I will be able to do whatever I want to do for myself. But just sitting here is not good for me. (Early 70-year-old residing in the facility for 2 years)

Being independent and having one's own possessions was integral to meanings attached to QoL:

> So, the quality of life, eish, yeah, I don't know what I can say but I don't think; it's much lower than what it used to be. I don't see anything; I don't know anything. If only I had my own things. Yes, things that will teach me. Things that entertain. It doesn't mean that when you're old, you no longer need things to entertain you. (Mid-80-year-old residing in the facility for 7 years)

Concerns about financial autonomy were also highlighted:

> Here you send someone (for errands) and they want a share of your money, you just see your money short.… There's nothing you can do. (Mid-70-year-old residing in the facility for 2 years)

Dignity and respect

Some residents felt respected and valued by the facility's staff, who provide essential services and treated them well. Being cared for, respected and not yelled at contributed to their sense of dignity. They valued a supportive environment where their needs are met without fear of mistreatment.

> They treat us so well here. We eat well… Here we bath and eat.… Here we talk and laugh, we eat and drink tea. (Mid-60-year-old residing in the facility for 6 months)

> They treat us well, they give us water, we bath and eat … we don't lack anything that we can complain

about. (Late 80-year-old residing in the facility for 1 year)

However, when they felt that they were a burden or lacked control over their finances, their sense of dignity was compromised. One resident's frustration with financial mismanagement illustrates the importance of transparency and agency in preserving dignity:

I think I still long to work but because I don't have any more strength left, it's not possible. (Early 70-year-old residing in the facility for 1 year)

Emotional well-being

QoL also involves emotional stimulation. Some participants felt the lack of activities or entertainment, which they regarded as essential in preventing boredom and maintaining mental engagement. They expressed a desire for more activities, such as games or social events, which had previously been available. For others, attending community events, such as weddings or being able to play games, provided a sense of engagement and normalcy. Opportunities to connect with the outside world or engage in meaningful activities were regarded as enrichment in their lives and provided joy.

If people can get something to do, that's something that I've been crying about. At some point, there were even games that used to be here.… We would play with the ball even as I'm in the wheelchair. (Mid-80-year-old residing in the facility for 7 years)

Participation in outside events, such as weddings, brought joy and a sense of normalcy:

Honestly, even when I'm out and I'm attending weddings at home, that's when I feel like a person and see things with my own eyes. (Mid-70-year-old residing in the facility for 6 months)

Acceptance and adaptation

Many participants found peace in accepting their current circumstances. They expressed a willingness to adapt to the facility environment, considering it as 'home' and making the best of their situation. This adaptation often emanated from a sense of resignation or pragmatism, acknowledging their limitations and the need to avoid burdening family members. A recurring theme was the resilience and acceptance of their current life stage, demonstrating an adaptive mindset that assisted in their coping with challenges and changes in their environment.

I just tell myself that the place I'm in right now, I need to get used to it and it's my home and I've made peace with it. (Early 70-year-old residing in the facility for 2 years)

For some, acceptance was intertwined with faith, as they regarded their situation as part of a divine plan.

You must just tell yourself that you were put in that situation by God.… Without that you won't be fine. (Late 60-year-old residing in the facility for 8 months)

DISCUSSION

This study underscores the relationship between the organisational structures of LTC facilities and the QoL of residents. Revealing how institutional frameworks influence physical, emotional, social and spiritual well-being (see table 1 above). By examining the mechanisms through which daily practices and policies shape residents' experiences, the study maps key dimensions of QoL—health, autonomy, social connectedness, dignity and spiritual fulfilment—to institutional operations and practices. The findings align with prior research which highlights the integral role of institutional structures in shaping QoL for LTC residents.[40–45] A systematic review conducted by Rodríguez-Martínez *et al*[44] identified that residents in facilities with robust healthcare delivery systems reported significantly better health outcomes, emphasising the importance of healthcare access as a determinant of QoL. In resource-constrained settings such as South Africa, where formalised LTC provision for older people is undergoing development, in comparison to the rest of Sub-Saharan Africa, there is a mandatory staffing model that regulates nurse and caregiver staffing levels in LTC facilities. However, despite these regulatory frameworks, challenges persist. An audit report compiled by a service provider for the National DSD in 2010 highlighted these issues.[31] The audit covered 405 LTC facilities across the country, revealing that financial constraints were a significant barrier to adequate staffing. These constraints led to insufficient numbers of nurses and caregivers, as well as an incorrect skill mix in many LTC facilities.[31] As a result, staff are often tasked with duties beyond their designated scope of practice, such as enrolled nursing assistants administering medication. This misallocation of staff resources compromises the consistency of care, affecting both access to and the quality of healthcare services for older individuals, as evidenced by the current study. Similarly, Caspar *et al* demonstrated that management practices directly influence residents' health and autonomy, particularly through staff training and efficient resource allocation.[41] While grossly inadequate, South Africa promotes training in gerontology for healthcare providers in its national ageing policy and supports institutions providing training. The current study contributes to these insights by providing an understanding of how resource constraints, such as staff shortages and inadequate training, exacerbate challenges in providing quality care. These challenges were particularly pronounced during the COVID-19 pandemic, underscoring the importance of crisis resilience in LTC facilities.[45] This study found that health-related QoL was dependent on timely healthcare delivery and sufficient staffing. However, the quality of care can

be compromised by the effects of staff burnout and high staff turnover when meagre resources are allocated.[46] The current study thus reaffirms that investing in staff capacity is crucial for sustained high standards of care. Moreover, there is a need for LTC facilities to implement supportive structures in order for their workforce to meet residents' needs.

Social connectedness has long been recognised as a cornerstone of QoL in LTC settings. Previous studies have emphasised the role of communal spaces and structured activities in fostering interpersonal relationships among residents.[44 47 48] This study corroborates these findings, but further identifies a persistent tension between institutional control and individual autonomy. Restrictions on residents' ability to make decisions regarding their social interactions and daily routines emerged as a barrier to meaningful engagement and QoL. It may be the case that allowing residents to exercise greater autonomy in these areas could enhance their sense of agency and overall well-being.

Spiritual fulfilment, a less frequently studied but equally critical aspect of QoL, was supported through regular spiritual activities and collaborations with religious communities. These findings align with Amoah and Adjei, who emphasised the role of cultural and spiritual practices in enhancing QoL in care settings.[49] The findings of the current study contribute new insights by highlighting the importance of integrating these practices into institutional routines, particularly in culturally diverse populations such as those in South Africa, where spiritual continuity is a vital component of holistic well-being.[50]

Physical space design emerged as another critical factor influencing autonomy and independence. Previous research has highlighted the importance of accessible and navigable environments in promoting residents' freedom and participation in daily activities.[42 51 52] The current study further highlights the centrality of dignity and emotional well-being in LTC environments. Aligning with Shin and Park,[53] who emphasised the role of person-centred care in fostering dignity, this study underscores how ethical care practices, such as respecting residents' privacy and preferences, enhance their sense of self-worth. Emotional resilience, supported by tailored psychosocial programmes and recreational activities, facilitates residents' adaptation to their new environment and to the development of their sense of belonging.

Limitations

The scope of this study is intentionally delimited by the standpoint of the key informants—in this case, older persons living in LTC facilities in a resource-constrained South African district. While this standpoint enabled a grounded exploration of how institutional processes shape QoL, it also means that the findings are not intended to be generalisable in the conventional sense. Instead, the aim was to map ruling relations and institutional texts as they are activated in the everyday lives of residents. The institutional data were necessarily shaped by what participants could articulate and what was made accessible by staff and gatekeepers within the selected facilities. Furthermore, access to texts was uneven across sites due to variability in documentation practices and institutional transparency, which may have limited the completeness of the institutional mapping. Despite these limitations, the study offers analytically rich insights into the social organisation of care and QoL, and the findings contribute to an expanding body of institutional ethnographic work in health and social care systems, particularly in under-researched, resource-constrained settings.

CONCLUSION

While existing research has explored various dimensions of QoL in LTC facilities, this study uniquely maps the interplay between organisational structures and the lived experiences of residents. It not only corroborates prior findings but also provides actionable insights into how institutions can bridge the gap between policy intent and operational realities. In resource-constrained settings such as South Africa, where government-subsidised LTC facilities face systemic challenges, such as funding inequities and staff shortages, these findings underscore the need for holistic, culturally responsive care models. This is especially significant given South Africa's legacy of apartheid, which was anchored in a policy of separate development, with Black people being systematically disenfranchised and marginalised. By mapping these connections, the study offers a practical framework for designing and implementing interventions that enhance QoL in LTC settings. It highlights the importance of integrating health, social and spiritual dimensions into institutional policies and practices, advocating for a shift towards person-centred care approaches that prioritise residents' holistic well-being. In focusing on the South African context, this study contributes to a growing body of literature that recognises the unique challenges and opportunities in resource-constrained environments. By addressing these challenges, LTC facilities may improve residents' QoL and serve as models for care practices in similar settings globally.

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Contributors NH and LN developed the research project from which data have been used. NH and LN analysed the data. NH drafted the first draft of this article. LN further edited the article. NH finalised the manuscript for submission. NH is the guarantor of the article and accepts full responsibility for the integrity of the work as a whole.

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Patient and public involvement Patients and/or the public were involved in the design, conduct, reporting or dissemination plans of this research. Refer to the Methods section for further details.

Patient consent for publication Not applicable.

Ethics approval This study involves human participants and was approved by Research Ethics Committee of Stellenbosch University (REC- S22/06/105). Participants gave informed consent to participate in the study before taking part.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement Data are available upon reasonable request.

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