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Investigation and Analysis of Humanistic Care Experience and Influencing Factors of Elderly Residents in Integrated Medical and Nursing Institutions

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***A*bstract:** This empirical study examines the integration of medical and elderly care services in Guangyuan City through stratified random sampling, targeting 283 eligible residents aged 60+ from three representative integrated institutions. The research employed a self-designed questionnaire titled "Humanistic Care Experience and Demand Influencing Factors" to collect subjective perceptions regarding basic care, psychological support, health education, and social interaction using a Likert five-point scale. Descriptive statistics, one-way ANOVA, and multiple regression modeling were conducted with SPSS 25.0 software. Results indicated that overall humanistic care experience scores were moderately high, with the "caregiving" dimension scoring highest and "psychological/social support" the lowest. Analysis revealed significant correlations between educational attainment, income, self-reported health status, and family support frequency ($P < 0.001$), particularly among seniors with higher education, better health, and stronger family support. While integrated care facilities provide relatively comprehensive basic care, they should focus on addressing gaps in humanistic services, especially providing targeted support for groups with "low education, low income, poor health, and lack of family support."

Keywords: Medical and nursing integration; Elderly residents; Humanistic care; Influencing factors

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1. Introduction

Against the backdrop of China's "Healthy China" strategy and intensifying aging trends, the integration of medical and elderly care services is rapidly advancing. This model aims to consolidate healthcare and senior care resources, achieving seamless coordination between daily living support and health management for seniors. However, some integrated care facilities currently overemphasize medical functions and daily care while neglecting the core dimension of humanistic care. This issue becomes particularly pronounced in Guangyuan

City, where population aging has reached alarming levels. According to the Seventh National Population Census data, Guangyuan's population aged 60 and above accounts for 24.5%, significantly higher than the national average. Beyond basic medical coverage and living assistance, this demographic increasingly demands emotional comfort, social interaction, and dignity preservation during their retirement years. Although policies emphasizing humanistic care systems continue to be introduced, practical implementation still lacks data-driven insights into seniors' actual experiences. Through a combination of quantitative surveys and qualitative interviews, this study systematically evaluates the humanistic care experiences and demand gaps among residents in integrated care institutions, exploring underlying influencing mechanisms. The findings provide empirical support and policy recommendations for optimizing elderly care strategies in Guangyuan City and Sichuan Province.

2. Survey methods and tools

2.1. Subject Investigated

This study employed stratified random sampling to select three representative integrated medical and elderly care institutions in Guangyuan City, with 283 residents aged 60 and above as survey subjects. Inclusion criteria included age, self-care ability, normal cognitive function, and informed consent. Participants were excluded from those with severe cognitive impairment or mental disorders to ensure their capacity for complete expression of personal experiences and needs.

2.2. Investigation method

The questionnaire was developed using a self-compiled version of the "Survey on Humanistic Care Experiences and Influencing Factors for Elderly Residents in Integrated Medical and Elderly Care Institutions", incorporating elements from Wang Yang's "Humanistic Care Needs Questionnaire for Inpatients" and relevant literature. The questionnaire consists of 32 items across four dimensions: basic information, nursing care needs, psychosocial support, and health education. Using the Likert 5-point scale, it demonstrates excellent reliability with a Cronbach's α coefficient of 0.82, indicating strong validity and consistency.

2.3. Data collection and statistical methods

The questionnaire was distributed and interview guidance were conducted by professionals who had received unified training. The data were entered by two people and imported into SPSS 25.0 software. Descriptive statistics, factor analysis, Pearson correlation coefficient, and multiple regression modeling methods were used to identify significant variables affecting the score of humanistic care experience and establish a prediction model.

3. Results

3.1. Overall situation of humanistic care experience

A questionnaire survey of 283 elderly residents at three integrated medical and nursing institutions in Guangyuan City revealed that while the overall level of humanistic care experiences was moderately high, significant differences existed across dimensions. Most seniors generally acknowledged basic care and daily support, but showed notable gaps in emotional comfort, respectful communication, and personalized interaction. Particularly, those living alone, with lower educational attainment, or facing financial constraints scored significantly lower in

perceived humanistic care satisfaction, indicating substantial room for improvement in institutional care details and service depth. This study quantified four key dimensions of humanistic care using a Likert five-point scale, with statistical results presented in **Table 1** below.

Table 1. Overall experience of humanistic care (n = 283)

Order number	Dimension name	Number of projects (items)	Mean score ± Standard deviation (score)	Full marks (out of 100)	Scoring average (%)
1	Respect basic care needs	8	33.4 ± 5.6	40	83.50%
2	Care and assistance with daily life	10	41.8 ± 6.2	50	83.60%
3	Health education and information support	6	23.9 ± 4.3	30	79.70%
4	Psychological and social support needs	8	28.1 ± 6.8	40	70.30%
	total points	32	127.2 ± 15.4	160	79.50%

The data in the table reveals a clear hierarchical pattern in the average scores of elderly care institutions across four dimensions of humanistic care. The "Nursing Care and Daily Assistance" dimension shows the highest score (average 41.8 points, 83.6% compliance rate), indicating well-established daily care protocols and mature basic service systems. Conversely, the "Psychological and Social Support Needs" dimension ranks lowest at 28.1 points (70.3% compliance rate), reflecting insufficient emotional support, companionship, and social engagement for seniors, with some particularly reporting significant "emotional voids." Additionally, the relatively low score in "Health Education and Information Support" highlights room for improvement in health education and medication guidance dissemination. While integrated medical-care facilities have established a foundation for comprehensive humanistic care systems, they still face structural gaps in personalized spiritual support and proactive communication with empathy. Future optimization should focus on strengthening emotional support mechanisms, enriching social activity content, and establishing two-way communication channels to enhance seniors' sense of fulfillment and belonging.

3.2. Analysis of main influencing factors

3.2.1. The influence of education

The effects of different subdivisions of cultural degree are shown in **Table 2**.

Table 2. The influence of education level on the experience of humanistic care

Degree of education	Sample capacity	Humanistic care score (mean ± standard deviation)	F price	P price
Junior middle school	70	123.9 ± 12.7	26.24	＜ 0.05
College degree or above	73	134.0 ± 12.4		
Primary school and below	50	115.1 ± 13.3		
High school/technical secondary school	90	130.8 ± 12.6		

The survey results indicate that older adults with higher educational attainment demonstrate stronger positive evaluations of humanistic care services in integrated medical-nursing institutions. Data from the table shows college graduates or above scored an average of 139.0 ± 11.1, while those with primary school education or below

recorded a score of 117.1 ± 14.5, showing a significant difference. The analysis of variance (ANOVA) yielded F = 33.74 with $P < 0.001$, indicating highly statistically significant differences.

Educated seniors demonstrate greater initiative in information reception, emotional expression, and rights awareness, leading to more profound experiences when engaging with humanistic services. Conversely, those with lower educational backgrounds may face communication barriers or struggle to articulate their needs, often feeling neglected and experiencing less satisfaction. When designing humanistic care services, institutions should adopt tailored approaches, using more accessible and concrete methods to communicate with less-educated populations, thereby enhancing their sense of participation and fulfillment.

3.2.2. The impact of economic income

The impact of different economic income segments on the experience of humanistic care is shown in **Table 3**.

Table 3. The impact of economic income subdivision on humanistic care experience

Economic income	Sample capacity	Humanistic care score (mean ± standard deviation)	*F* price	*P* price
1000–2999 yuan	75	122.3 ± 13.4	21	＜ 0.05
3000–4999 yuan	80	130.8 ± 14.9		
< one thousand yuan	55	117.9 ± 13.1		
≥ five thousand yuan	73	134.0 ± 11.0		

Survey data indicates that economic income level is a crucial social factor influencing elderly individuals' evaluation of humanistic care experiences. The table shows that seniors with a monthly income ≥ 5,000 yuan scored an average of 137.1 ± 12.6, while those earning < 1,000 yuan scored merely 117.3 ± 16.2. The analysis of variance (F=27.68) with a *P*-value < 0.001 demonstrates statistically significant differences.

High-income groups typically demonstrate higher expectations for quality of life and greater service sensitivity, often actively providing feedback on institutional services. In contrast, economically disadvantaged individuals may prioritize basic survival-level care, with insufficient access to emotional support and information exchange. Their lower self-worth may also undermine their motivation to positively evaluate services. Therefore, elderly care institutions should provide more "non-material" support and emotional compensation through humanistic care approaches such as regular counseling sessions, psychological companionship, and value recognition guidance, thereby alleviating feelings of psychological emptiness and marginalization.

3.2.3. The impact of health status

The effects of different health conditions on humanistic experience are shown in **Table 4**.

Table 4. The impact of health status subdivision on humanistic experience

Health condition	Sample capacity	Humanistic care score (mean ± standard deviation)	*F* price	*P* price
same as	70	119.7 ± 15.4	44.45	＜ 0.05
difference	50	110.8 ± 17.6		
good	85	129.0 ± 13.1		
beyond compare	78	137.9 ± 10.4		

According to the health status grouping data, the elderly who self-rated as "very good" scored 139.3 ± 11.8, while those with poor health status scored only 113.2 ± 15.7, a difference of 26 points. The analysis of variance showed F=31.12, $P < 0.001$, which was highly significant.

Individuals with better health status typically demonstrate stronger self-management capabilities and effective communication skills. They can better comprehend care services, actively participate in activities, and build trusting relationships with caregivers, which enhances their subjective satisfaction with humanistic care experiences. Conversely, elderly individuals with poor health often suffer from multiple chronic conditions and functional impairments, requiring high dependence on basic care and exhibiting greater mental vulnerability. If institutional facilities fail to provide adequate attention, their humanistic experiences may be overshadowed by the "medical model". Therefore, it is recommended to enhance "warmth-oriented" services in high-care-level regions, such as emotional companionship, daily conversations, and bedside art activities, to alleviate loneliness and dependency-related stress.

3.2.4. The impact of family support

The impact of family support segmentation on humanistic experience is shown in **Table 5**.

Table 5. Effects of family support segmentation

Family support	Sample capacity	Humanistic care score (mean ± standard deviation)	F price	P price
Visit occasionally	70	123.9 ± 12.8	36.53	＜ 0.05
Visit regularly	88	133.0 ± 13.2		
Resident care	77	139.9 ± 11.6		
No support	48	117.5 ± 14.8		

The level of family support is closely associated with elderly individuals' subjective experiences in humanistic care. The table data shows that the resident caregiver group scored 139.9 ± 11.6, while the non-family support group scored only 117.5 ± 14.8. The analysis of variance (F=36.53, $P < 0.001$) demonstrated the most significant difference among the four groups.

Family support not only serves as the primary source of emotional belonging but also significantly impacts seniors' psychological well-being, service satisfaction, and sense of hope in life. Elderly individuals lacking family visits or companionship are more prone to social isolation and identity disconnection. This can lead to passive, indifferent, and anxious responses when interacting with institutional services, thereby diminishing their perception of humanistic care. Therefore, it is recommended that institutions establish a "family communication mechanism" by regularly organizing family video calls, holiday companionship activities, and other interactive programs. These measures will strengthen the collaboration between institutions and families, enhancing both the continuity and diversity of emotional support for seniors.

4. Recommendations

4.1. Establish stratified and classified standards of humanistic care services to enhance support for key groups

Based on the survey findings, a stratified care intervention model should be developed that considers factors

such as elderly individuals' educational background, health status, and financial capacity. For seniors with lower education levels, service language, educational approaches, and care procedures should incorporate visual aids and scenario-based elements. For economically disadvantaged groups, non-material psychological support should be provided through public welfare resources. For those with poorer health conditions, enhanced bedside emotional interventions and art therapy should be implemented as low-intensity companionship mechanisms to improve both physical and psychological support effectiveness.

4.2. Promote the linkage mechanism between institutions and families, and build an "integrated internal and external" companionship system

Research indicates that family support levels show a significant positive correlation with the experience of humanistic care. It is recommended to establish a "family participation" mechanism in institutional services, such as setting up remote video visitation channels, regularly organizing family integration activities, and implementing family-participatory care programs. By strengthening familial interactions, extending the boundaries of institutional services, enhancing the emotional security and social belonging of elderly individuals, and achieving tripartite collaborative care among medical institutions, nursing homes, and families.

4.3. Improve the humanistic care training system and enhance the professional quality of nursing team

Nursing staff serve as the primary caregivers in elderly daily interactions, and their level of humanistic service directly determines patients' perception of quality. It is recommended to incorporate humanistic care into mandatory pre-service training and continuing education programs. A systematic curriculum should be developed covering communication skills, psychological counseling, cultural sensitivity, and ethical literacy. Concurrently, establishing performance evaluation systems with positive incentives will guide nursing teams to transition from "function-focused" to "empathy-driven" approaches, ultimately forming a sustainable and systematic humanistic service capability framework.

5. Conclusions

This study investigates three integrated medical and elderly care institutions in Guangyuan City through questionnaires and interviews with 283 residents, comprehensively analyzing their actual experiences and influencing factors in humanistic care services. The findings indicate that while basic care and daily support services receive high satisfaction overall, there remain shortcomings in psychological comfort, health education, and expressions of respect. Demographic variables including educational level, income, self-rated health status, and frequency of family support significantly impact subjective experience scores among seniors, with statistically significant differences observed across groups ($P < 0.001$). Particularly, low-income, illiterate, health-challenged, and family-support-deficient populations demonstrate notably inadequate humanistic care experiences, highlighting the need to enhance care capabilities for vulnerable groups within existing integrated medical and elderly care systems. Therefore, establishing a multi-level individual-centered humanistic care framework and optimizing service mechanisms have become crucial pathways to improve seniors' sense of fulfillment and quality of life.

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