Journal of Aging Studies 37 (2016) 1–9

Contents lists available at ScienceDirect

Journal of Aging Studies

journal homepage: www.elsevier.com/locate/jaging

Witnessing presence: Swedish care professionals' experiences of supporting resident's well-being processes within the frame of residential care homes (RCH)

Anette Lundin [a,b,*], Lars-Erik Berg [c,1], Ulla Hellström Muhli [d,2]

[a] *School of Health Sciences at Jönköping University, Sweden*
[b] *School of Health and Education, University of Skövde, Sweden*
[c] *School of Health and Education, University of Skövde, Högskolan i Skövde, AINstitutionen för Hälsa och Lärande, Högskolevägen, Box 408, SE 54128 Skövde, Sweden*
[d] *Department of Sociology (Faculty of Social Sciences), Uppsala University, Sociologiska Institutionen, Box 624, SE 751 26 Uppsala, Sweden*

ARTICLE INFO

Article history:
Received 2 April 2015
Received in revised form 4 December 2015
Accepted 23 January 2016
Available online 22 February 2016

Keywords:
Supportive care
Well-being
Lived experience
Care professionals
Residential care home

ABSTRACT

The purpose of this article is to analyse the phenomenon of supportive care for older persons' well-being. The phenomenon is seen from the eldercarers' meaning-making through their lifeworld perspective at a residential care home. Based on primary empirical interview material with twelve professionals in the context of Swedish eldercare, a phenomenological analysis was undertaken.

The *result* shows that the phenomenon of supportive care for older persons' well-being creates certain ambiguities in the professionals' meaning-making. In practice, it balances between the older persons' (from hereon called residents) needs and the conditions of the eldercare organization. The ambiguities (the *what*) is made up by three constituents: (i) freedom of choice for the older persons vs. institutional constraints, (ii) the residents' need for activation vs. wanting not to be activated, and (iii) the residents' need for routine vs. the eldercarers' not being able to know what the residents need.

The *conclusions* drawn are that this ambiguity has consequences for the eldercarers' choice of handling supportive care for older persons' well-being (the *how*). They have to navigate between the support for authenticity, dwelling and mobility, and their own presence and time. In performing supportive care for older persons' well-being, the eldercarers have to consider aspects concerning the resident's lifeworld, the social setting of the eldercare ward, and the institutional demands of the organization. The *practical implications* for supporting well-being in the care of older residents are manifested in the importance of 'the little things', and the eldercarer's ability to give receptive attention, which requires presence.

Introduction

What is the natural attitude to and meaning of supportive care for well-being, and in what way do care professionals (from hereon called carers) experience supportive care for well-being of older persons at a residential care home (RCH)? Does the meaning-making have a humanistic characteristic and a genuine wish to create well-being, or is it a relationship of the carer with his/her institutional context? These kinds of questions must be raised in order to increase the quality of the care of the oldest old citizens, here the residents at the RCHs.

In Sweden, the oldest old people's (80 years and older) well-being is recognized as a pervasive and growing request deserving the attention of carers (Sherlund & Larsson in Dunér, 2007; Socialstyrelsen [The National Board of Health

---

[*] Corresponding author at: Högskolan i Skövde, Institutionen för Hälsa och Lärande, Högskolevägen, Box 408, SE 54128 Skövde, Sweden. Tel.: +46 734411897, +46 500448246.

E-mail addresses: anette.lundin@his.se (A. Lundin), lars-erik.berg@his.se (L.-E. Berg), ulla.hellstrom_muhli@soc.uu.se (U. Hellström Muhli).

[1] Tel.: +46 731542442.

[2] Tel.: +46 703047606, +46 184715172.

http://dx.doi.org/10.1016/j.jaging.2016.01.001

and Welfare], 2009, 2012; SOU, 2008:18). This request is made explicit by one of the most important principles of Swedish policy stating that older persons who receive eldercare should be able to live a dignified life and experience well-being (The National Board of Health and Welfare, 2012). This principle is expected to be achieved by safeguarding and respecting the individual's right to private life and bodily integrity, self-determination, participation, and by customizing care to individual needs. The issue of supportive care for well-being is therefore of particular interest for residents in RCHs. They are in general terms seriously ill, fragile and dependent, and often have multi-functional impairments. In other words, they have a great need of supportive care for well-being as well as value-based social and health care services to live a dignified life.

Quality measurements of the residents' satisfaction of care at the RCH show that despite the physical and psychological declining capacities, they are satisfied with the safety, treatment, health care achievements, and the living environments within the RCH. On the other hand, residents reported dissatisfaction when it comes to opportunities to influence the amount of time in getting help. They also expressed dissatisfaction with how the carers consider their point of view and wishes, and they found the social interaction and community at RCH less positive. These kinds of less positive expressions are well known from other literature as well (e.g. Berglund, 2007; Burstow, 2013; Glendinning, 2014; Harnett, 2010; Hellberg, Augustsson, & Hellström Muhli, 2011; Hummert, Wiemann, & Nussbaum, 1994; Jacelon, 1995; Porter & Clinton, 1992; Troyer & Sause, 2011; Walker, 2014).

The present framework captures the dimensions of the resident's (as described by the carers) experiences and reflects the caring relationships and the intrapersonal experiences of receiving care. However, the framework also captures the dimension of interpersonal experiences of giving care and that the care involves two individuals. It also represents the interface between the care profession, the institution and the residents. The carers must therefore handle these different perspectives in the care giving practices. The question is how they do it? A study by Hellström Muhli (2010) shows that caregivers (for example welfare officers) handle this by unreflectingly navigating between different perspectives, compromises and double approaches. The carers' navigation also contains different types of interaction (language, problem definition, dialogue norms, and compromises between the institutional system-world and the client's lifeworld (Hellström Muhli, 2010). However, the tension between these worlds will be further developed in a forthcoming article. In this study, we intend to conceptualize this complex interplay of expectations, feelings and attitudes from the carers' view.

The caring culture at RCH is challenged to meet the increasing needs and well-being of the residents. As Ranheim, Kärner, and Berterö's (2011) study shows, the bureaucratic aspects of care organizations do not always make the humanistic aspects visible in the caring culture. The professional practice of care is not always in line with the intentions. This creates frustration (Lundin, Berg & Hellström Muhli, 2013). The organizational demands can also lead to a creation of routines characterized by "hurrying" and not being able to meet the residents as unique individuals (Fagerberg & Engström, 2012). When the carers feel that they cannot deliver the intended care because of time pressure, a moral distress arises de Veer, Francke, Struijs, & Willems, 2013. This moral distress is due to several interests and values being at stake at the same time. Low or unsafe staffing levels have been shown to contribute to moral distress (Burston & Tuckett, 2012). Gjerberg, Førde, Pedersen, and Bollig (2010) found that a lack of resources led to inadequate psycho-social care. This inadequacy was experienced as an ethical dilemma; with a low level of staffing, the freedom of movement for the residents was restricted. The carers working closest to the residents experienced more ethical dilemmas than those working less closely (e.g. managers). As can be seen, there is a tension between the professional aspirations and institutional constraints. With this in mind, it is important to understand the carers' thoughts and meaning-making about supportive care for the well-being of the residents.

Supportive care for well-being

The concept of caring captures the meaning of giving care to those who cannot perform a particular task. Thereby it also captures the dimensions of a disadvantage in the caring relation. Accordingly, the specific logic of the care (the caring rationality) involves aspects of asymmetries, morality, and human values, at the same time as the care must be planned, valued and acted upon (Waerness, 1984). The objective of care is well-being and quality of life. With reference to Mayeroff (1999), caring is about initiating a person's health and well-being processes by providing room for growth and development.

The concept of well-being has attracted attention from diverse academic disciplines, but it is still vaguely defined and described and it is only with difficulty concretized in the eldercare (Lundin et al., 2013; Svensson, Mårtensson, & Hellström Muhli, 2012). In this study, well-being will be defined as an existential experience. As such, it does not suppose intact cognition. This definition suggests that elderly with dementia, living at RCH, who are unable to communicate their needs, are still entitled to receive care supporting well-being.

In recent years, the interdisciplinary field of well-being studies has produced a growing body of research dealing with caring and well-being in health and social care institutions (Diener, 2009; Hellberg et al., 2011). These findings highlight the importance of social relations and social interactions between the carers and the residents. Carers' experiences of well-being of residents at RCH are characterized as feelings of being existentially touched (Lundin et al., 2013). This experience entails feelings of freedom of choice, of pleasure and closeness — aspects that make up the carers' *care values*. Accordingly, to support the resident's well-being is to support the conditions *of being* and leads the carer in practice to help the resident to feel and to experience different kinds of existential life desires. These dimensions of existential experiences of well-being refer to the phenomenological concept of emotions and are understood as being-in-the-world of acceptance (Heidegger, 1927/1981), which emphasizes authenticity. This implicates a self that defines itself and a balance between existential dwelling and existential mobility (Todres & Galvin,