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Enabling at-homeness for residents living in a nursing home: Reflected experience of nursing home staff

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ABSTRACT

Older people are often living the last period of their lives in institutions such as nursing homes. Knowledge of this period, specifically related to at-homeness which can be described as wellbeing in spite of illness and has been regarded as one of the goals in palliative care, has been very little researched in the context of nursing homes and the experience of nursing home staff. The aim of this study was to explore the experiences of nursing home staff of how to enable at-homeness for residents. Qualitative interpretive description methodology guided the design. The data generation was conducted in winter 2014–2015, when seven repetitive reflective group discussions with staff in a nursing home were held. The results show five patterns for how healthcare staff enabled at-homeness for the residents: Striving to know the resident, Showing respect for the resident's integrity, Creating and working in family-like relationships, Helping to find a new ordinariness and Preparing and making plans to ensure continuity. Nursing home staff seem to have collegial knowledge of how to enable at-homeness for the residents in a nursing home. Close relationships with respect for the resident's integrity stand out as enabling at-homeness.

Introduction

This paper focuses on how nursing home staff can enable at-homeness for residents. Encounters with staff in nursing homes have been regarded as crucial for residents' wellbeing (Westin & Danielson, 2007) and the everyday activities of the residents has been reported as an important aspect of thriving (Edvardsson, Watt, & Pearce, 2017).

The staff in nursing homes who work most closely with the older people are often nursing assistants who have high school level education or less (Hewko et al., 2015) and limited training or education for their work (Estabrooks, Squires, Carleton, Cummings, & Norton, 2015). It has been shown that their professional roles are unclear (Hewko et al., 2015) and they have a high level of burnout, which may have implications for the quality of care (Estabrooks et al., 2015). Despite being a demanding area of work, nursing assistants experience job satisfaction in their work with older people (Eldh et al., 2016; Estabrooks et al., 2015), which enables personal and professional growth (Eldh et al., 2016).

Aging in place has been seen as an important policy in many countries (Bookman, 2008; Mitty & Flores, 2008) and older people are supported so that they may live in their own homes for as long as possible (Sixsmith & Sixsmith, 2008). In Nordic countries, the policy of care for older people has changed in recent decades and the practice has moved from long-term units focusing on medical treatment to more home-like units where the older people are formally rental guests; a consequence of the aging in place policy (Sweden Statistics, 2006). Globally, and in Sweden, there is an increase in the number of older people who are living the last period of their lives and dying in institutions, such as nursing homes and hospitals, rather than in their own homes (Håkanson, Öhlén, Morin, & Cohen, 2015; Reyniers et al., 2015; Sarmento, Higginson, Ferreira, & Gomes, 2016).

Older people who move into nursing homes are often severely ill (Estabrooks et al., 2015) with conditions that may indicate a need for palliative care (cf. Morin et al., 2016). In Sweden, for example, older

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people often die less than ten months after they have moved into a nursing home (Schön, Lagergren, & Kareholt, 2016; Smedbäck et al., 2017). In general, studies on the use of a palliative approach with older people in nursing homes have, in recent decades, been of growing interest (Casey et al., 2011; Goddard, Stewart, Thompson, & Hall, 2013; Goldstein & Morrison, 2005; Hallberg, 2006). However, there is still a need for fundamental development of a palliative approach in the care of people with chronic life-limiting conditions (Sawatzky et al., 2016). Achieving at-homeness has been proposed as one of the goals of palliative care (Dekkers, 2009), however knowledge about how to facilitate this is lacking.

At-homeness in all age groups has been studied by Zingmark, Norberg, and Sandman (1995) who found that at-homeness meant being metaphorically at-home and was related to significant others, places, activities and things (Zingmark et al., 1995). At-homeness can be regarded as an aspect of wellbeing and can be experienced despite severe illness (Öhlén, Ekman, Zingmark, Bolmsjö, & Benzein, 2014). Furthermore, older people's at-homeness with regard to place has been described as a place of safety, comfort (Moloney, 1997) and as a therapeutic environment (Edvardsson, 2008). Earlier studies on at-homeness in relation to older people are scarce and knowledge concerning how nursing home staff relate to and enable at-homeness for older people in a nursing home is limited. Hence, it is important to understand and study how nursing home staff are able to enable at-homeness for older people living in nursing homes. Such knowledge is needed for the development of interventions that could facilitate nursing care directed towards the goals of palliative care in the context of nursing homes.

Aim

The aim of the study was to explore nursing home staff's experiences of how to enable at-homeness for residents living in a nursing home.

Design and method

Interpretive description by Thorne (2016) was chosen for the design of this qualitative study. Group discussions were used to generate experience-based knowledge from nursing home staff. Interpretive description provides understandings of complex clinical phenomena, where the purpose is to be relevant and useful in practice (Thorne, 2016).

Setting, sampling and participants

The setting for this study was a unit in a large private non-profit nursing home for older people in a large city in Sweden. The researchers contacted the nursing home manager to ask about willingness to participate in the study. The researchers requested the participation of a unit that the manager regarded as providing quality care in terms of the majority of the staff having a relevant education, low staff turnover and having an open working climate where the staff felt comfortable sharing experiences of sensitive issues related to their work. The unit for the study was therefore recommended by the manager of the nursing home based on these criteria. The actual unit had 11 single rooms with kitchenette, toilet and shower in every room and with residents being required to use their own furniture in their room. The unit had a large kitchen where meals were prepared next to a combined eating and living room where the residents were able to sit, eat and participate in social activities together. The main reason for residents being eligible to live in this unit was their extended need for nursing care, primarily due to stroke or other somatic diagnoses leading to functional impairment.

The participants in the study were eight nursing assistants, one registered nurse and one occupational therapist who all worked in the unit. All staff who were asked to participate in the study agreed, which gave a total of 10 participants (2 men and 8 women). Those who agreed to participate did so after being given oral and written information by the first author (LS). The participants were of various ages. Four participants were born in Sweden or other Nordic countries and six were born outside of Europe. One participant had no healthcare or social education, seven had nursing assistant education and two had university level education. The majority of the participants had worked at the nursing home for several years.

Ethical considerations

During recruitment for this study it was possible that the staff might have felt obliged to participate since they did so during their working hours and the manager had brought in extra staff to the unit to enable participation. However we did not notice that anyone felt an obligation to participate, responses after the group discussions were positive and the staff expressed being happy to participate in the sessions. Written informed consent was obtained from the staff and, before every group discussion session, the moderator (LS) ensured that the participants were willing to be audio recorded, thus repeated informed consent was applied (Seymour & Ingleton, 1999). The Regional ethical review board of Stockholm approved the study (2013/252-31/5 and 2014/1494-32).

Data generation and analysis

Reflective group discussions were chosen for data generation, which give an opportunity for healthcare professionals to achieve distance from their everyday practice through dialogue (cf. Bengtsson, 1993, 1995). This collegial knowledge is a result of the experiences from practice that are expressed for each other and, according to Bengtsson (1993), knowledge obtained from dialogue exceeds knowledge obtained through self-knowledge. A total of 7 group discussion sessions were held approximately 2–3 weeks apart during winter 2014/2015 and took place in a staff room at the nursing home. The conversations lasted between 30 and 80 min, with an average of about 60 min, and were audio recorded. In the six discussions, only nursing assistants who were at work at the time of the actual group discussion participated. One discussion was conducted with a registered nurse and a registered occupational therapist who had not taken part in the previous discussions due to their workloads. The nursing home had arranged for extra staff to work during the time the group discussions were held, which enabled the regular staff to participate in the study.

The moderator (LS) had a planned focus (see Table 1) for each group discussion. Every session had the same structure with an introduction, working process and feedback from the actual group discussion to enable the moderator to learn how to improve the next group discussion. After every group discussion, the moderator wrote a descriptive summary on paper so those participants who had missed the session could catch up on the theme and so that all the participants could be prepared for the next discussion. The moderator (LS) prepared coffee and cakes for each session to create a welcoming and friendly atmosphere for discussion and to show appreciation to the staff for their participation.

All the group discussions were transcribed verbatim and listened to several times to capture the narrative as a whole. The coding and organization of data were initially conducted broadly (Thorne, 2016) through inductive searching for patterns within the transcripts. Memos about understandings, linkages and interpretations were written beside the text units. The memos guided the analytical process and the continued interpretations. This was a process of moving backwards and forwards, between the texts as a whole and the text units with the memos. The interpretations were discussed and processed continuously with the authors of the study. Earlier research of at-homeness was read to expand the researchers' understanding of the participants' experiences of how to provide at-homeness among older people. Parallel with the analysis, reading of related literature enabled increased understanding of the material which, according to Thorne (2016), gives a deeper understanding of the aim being studied.