


Enabling At-Homeness for Older People With Life-Limiting Conditions: A Participant Observation Study From Nursing Homes

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Abstract

At-homeness, as an aspect of well-being, can be experienced despite living with life-limiting conditions and needs for a palliative approach to care. In nursing homes, older residents with life-limiting conditions face losses and changes which could influence their experience of at-homeness. The aim of this study was to explore how nursing staff enable at-homeness for residents with life-limiting conditions. Interpretive description was employed as the design using data from participant observations and formal and informal interviews related to nursing care situations. The strategies found to be used to enable at-homeness comprising nursing staff presenting themselves as reliable, respecting the resident's integrity, being responsive to the resident's needs, collaborating with the resident in decision-making, and through nurturing comforting relationships. The result on how to enable at-homeness could be used as strategies for a person-centered palliative approach in the care for residents in nursing homes.

Keywords

at-homeness, care relationships, nursing home, nursing staff, older people, participant observation, palliative care, person-centeredness

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Introduction

This study focuses on how nursing staff in a nursing home can enable at-homeness for residents with progressive life-limiting conditions. At-homeness is experienced at all ages in relation to oneself, significant others, things, significant places, activities, and transcendence (Zingmark, Norberg, & Sandman, 1995) and can be understood as a contextually related aspect of well-being (Öhlen, Ekman, Zingmark, Bolmsjö, & Benzein, 2014). Residents who are living with severe illness at the end of life may experience many losses and changes related to their body, their dwelling, and social relations with others (Nicholson, Meyer, Flatley, Holman, & Lowton, 2012). Some challenges and losses have been related to the experience of at-homeness, more specifically to hovering between metaphorically being at home and metaphorically being homeless (Öhlen et al., 2014). At-homeness may be a challenge for older people to experience because of the transition from living in their own home to a nursing home (or residential home, or similar) where the process of integration into a new environment could result in experiences of at-homeness or homelessness (Molony, 2010). For

older people, chronic illness may also contribute to a person experiencing a separation from their own life resulting in a feeling of otherness that has been explained as unhomelikeness by Svenaeus (2011). However, feeling at-home has been reported despite the presence of illness (Ekman, Skott, & Norberg, 2001; Öhlen et al., 2014).

Globally, the vast majority of older people are spending the last period of their life in hospitals and nursing homes (Håkanson, Öhlen, Morin, & Cohen, 2015; Reyniers et al., 2015; Sarmiento, Higginson, Ferreira, & Gomes, 2016). This is also the case in Sweden where the probability of dying in a nursing home increases with advancing age (Håkanson

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et al., 2015). It has also been shown that, in Sweden, residents' length of stay in nursing homes has decreased in the last decade (Schön, Lagergren, & Kareholt, 2016); more than half of residents died less than 10 months after they had moved into a nursing home (Schön et al., 2016; Smedbäck et al., 2017). This period of around 10 months or less is the time frame we use in this study to define the end of life. Moreover, research from Western/Northern societies shows that older people who live in nursing homes are often severely ill (Estabrooks et al., 2015), with gradually declining illness trajectories (Finucane, Stevenson, & Murray, 2017), and have more than one life-limiting condition (Fleming et al., 2017), thus reflecting the need for a palliative approach to their care (Morin et al., 2017). According to World Health Organization (2002), palliative care is

an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

Here, in this study, we use the broader meaning of a "palliative approach" to care, that is characterized by being a holistic vision (patient as a whole) supporting the person's dignity and well-being throughout life. For older people with progressive life-limiting conditions, it is crucial that the principles of a palliative approach can be integrated across care services (Sawatzky et al., 2017), including nursing homes, where the staff might have—or are expected to have—basic education and knowledge about a palliative approach (cf. European Association for Palliative Care, 2009).

Other studies show that older people do not always present with a need for a palliative approach in their illness trajectories, which could explain why they may receive less of a palliative approach to their care (Lloyd et al., 2016). Sometimes, it is unknown for older people themselves that they are living their last days of life (Hunt, Shlomo, & Addington-Hall, 2014; Klindtworth et al., 2015) and professionals' view is that only every fourth resident and every second family member had an end-of-life discussion before the death (Smedbäck et al., 2017), which probably contributes to a delay in introducing a palliative approach.

The palliative approach to care of older people in nursing homes has been recognized as an important area to develop. Inadequacies in the palliative approach for older people have received attention from researchers and global health care policies for more than a decade (Bennett, Davies, & Higginson, 2010; Froggatt et al., 2006; Hallberg, 2004). Following this, it has been declared that a palliative approach for older people is an urgent public health issue in need of development. In the future, the needs for a palliative approach to care of older people will grow with the increasingly aging population. Older people who are living and dying in nursing homes have unmet needs related to illness, diseases (Törnquist, Andersson, &

Edberg, 2013), and loneliness (Österlind, Ternstedt, Hansebo, & Hellström, 2017), and nursing home staff do not have the appropriate education to practice a palliative approach to care (Fryer, Bellamy, Morgan, & Gott, 2016; Goddard, Stewart, Thompson, & Hall, 2013). The staff responsible for this care to older people in nursing homes are for example, registered nurses together with occupational therapists and physiotherapists in Sweden. registered nurses together with occupational therapists and physiotherapists in Sweden (Törnquist, 2004). For the provision of the care, nursing assistants often work most closely with the older people and provide most of the actual care; however, nursing assistants' job descriptions vary depending on the work setting (Hewko et al., 2015). Still, the usual working tasks of nursing assistants in a Swedish context have been described as nursing care, social intercourse, and household, medical, and administrative tasks (Törnquist, 2004). As a consequence of the division of tasks, registered nurses in nursing homes have been described as being a consultant concerning older people's medical issues and everyday care and also having a formal role as leaders for nursing assistants (Karlsson, Ekman, & Fagerberg, 2009).

In a nursing home study based on participant observation data, it was found that care involving a palliative approach was the most important element of the care and that registered nurses had a key role in such care (Emilsdóttir & Gústafsdóttir, 2011). Another participant observation study focusing on older people's end of life in nursing homes showed that nursing staff can influence the care relationship through how they behave in relation to the older person (Spichiger, 2010).

At-homeness has been proposed as a goal for palliative care (Dekkers, 2009), and thus supporting at-homeness could be a way of promoting a palliative approach to the care of older people in nursing homes. However, there is limited research focusing on at-homeness in the context of older people in need of a palliative approach to their care in nursing homes. Earlier studies on at-homeness among older people with severe illness revealed that being oneself and being connected with others were the main aspects of at-homeness (Saarnio, Boström, Gustavsson, & Öhlén, 2016) that are temporally and spatially shaped, either momentarily or over time, in ways where earlier experiences and expectations are interwoven with place-related experiences and other people (Saarnio, Boström, Gustavsson, Hedman, & Öhlén, 2018). These earlier studies on at-homeness among older people were based on interview data; we found only one study based on participant observation, which is Edvardsson (2008) who reported that therapeutic environments enabled at-homeness for older people in nursing homes. There is limited research on how at-homeness may be enabled for residents living at the end of their life in a nursing home. Moreover, there are few studies in nursing home settings on older people's end of life using empirical data other than interviews. Participant observations, for

example, would be a way to generate knowledge about how at-homeness is enabled in practice.

Aim

The aim of this study was to explore how nursing staff enable at-homeness for residents with life-limiting conditions cared for in a nursing home.

Method

Design

Fieldwork with an interpretive description design (Thorne, 2016) was chosen for guiding the data generation and analysis. Thorne (2016) emphasizes that an interpretive description approach is adequate in research that seeks to develop knowledge from a practice knowledge interest. It is therefore suitable for this study which aims to develop knowledge on how residents' at-homeness is enabled by nursing staff. Data generation was based on participant observations supplemented by interviews with the observed residents and the nursing assistants. The analysis was based on constant comparative analysis, as proposed by Thorne (2016).

Settings and Participants

Two nursing home units, one long-term and one short-term, in two larger cities in Sweden were recruited for the study in 2015 and 2017. One unit was situated in a higher socioeconomic area and one on the outskirts of a mixed socioeconomic area with some dominance of working-class inhabitants. Purposeful sampling principles were applied (Thorne, 2016). The long-term unit was chosen because it had an open work climate, the majority of the staff had a relevant education, there was low staff turnover, and it had a work culture with willingness for development. To supplement data from a setting explicitly focusing on a palliative approach to care for older people with progressive life-limiting conditions, a nursing home with a palliative orientation to care was chosen and this setting was the short-term unit. The long-term unit accommodated 11 older people and the short-term unit 22 people, with 16 beds allocated for rehabilitation and six beds for a palliative orientation to care. Both units provided single rooms with toilet and shower, and in the long-term unit there was also a kitchenette in every room. In both units, there was a larger shared kitchen combined with living area (one in each of the units) with TV and sitting room furniture and a place for a kitchen table and chairs. The admission criterion for both nursing homes was a need for nursing care 24/7 and, for both the long-term and short-term units, there was an explicit policy that residents should be allowed to remain there until their death (except from the short-term rehabilitation beds). The length of stay at the nursing homes of the participating residents varied; even

if some residents had lived in the same nursing home for a couple of years (only in the long-term unit), some of them had stayed 2 to 4 months and some of them just days or weeks. Residents in the palliative orientation to care beds at the short-term unit were informed that a palliative approach was practiced; however, this varied at the long-term unit depending on how ill the residents were when moving into the nursing home.

Residents and nursing staff in both units were recruited for participation in the study. The inclusion criteria for residents were age 85 years or more, diagnosed with a progressive or chronic life-limiting condition, multimorbidity and/or receiving palliative care, and the ability to communicate in Swedish. For the staff members, the inclusion criterion was regularly taking care of residents. The participants from the short-term unit were mostly from the palliative orientation to care beds, although there were some participants cared for in the rehabilitation beds who met the inclusion criteria and were included in the study.

In total, 13 residents and 14 staff members received verbal and written information about the study and participated. These comprised five residents and seven staff in the long-term unit and eight residents and seven staff in the short-term unit. Of those invited, five residents and one staff member did not want to participate. To meet purposive sampling criteria, participants had a variety of backgrounds and the residents included 11 women and two men aged between 85 and 103 years. Of these, one had a living partner, all had children, and 11 were born in Sweden and two in other European countries. They had one or several medical diagnoses related to dementia, cancer, and circulatory and respiratory conditions. The participating staff in both units were 10 women and four men who were nursing assistants aged between 18 and 61 years and who had been working in health care from 2 months to 36 years and at the current units from 2 months to nearly 20 years. All except one of the nursing staff had fulfilled or were enrolled in nursing assistant education, which in Sweden is at high school level. Six of the staff were born in non-European countries (Asia and Africa) and eight were born in Sweden or other Nordic countries.

Data Generation and Analysis

Participant observations and interviews (Mulhall, 2003; Thorne, 2016) were performed during a 2-month period in 2015 in the long-term unit and a 2-month period in 2017 in the short-term unit (see details in Table 1). The first author conducted the participant observations and the formal and informal interviews with staff and residents regarding the observed care situations. The first author wore similar work clothes to those of the staff when visiting the units for participant observations. The situations that were observed occurred in residents' rooms, in corridors, or in the kitchen and living room areas. Sometimes, the researcher sat in a chair and observed interaction situations between residents and staff,

Table 1. Observations and Interviews.

Place	Participant Observations (n)	Participant Observations (hr)	Informal Interviews (n)	Formal Interviews (n)
Nursing Home 1	12	40	2	3
Nursing Home 2	25	135	9	14
Total	37	175	11	17

more commonly in the first part of the fieldwork, and sometimes the researcher was involved in care situations together with one or two nursing assistants, increasingly frequent in the latter part of the fieldwork. Unstructured field notes were made as detailed as possible and were sometimes made during the observations although mostly soon after the observed situations (cf. Mulhall, 2003). Even though the fieldwork was unstructured, the field notes were divided into as detailed as possible descriptions of the observed situation and then reflections and interpretations.

The formal interviews with residents and nursing assistants were conducted, if possible, on the same day as the observation. Occasionally, the residents were too tired to be interviewed on the same day or the nursing assistants were too busy, so some interviews were held later. The informal interviews with staff occurred during breaks, following a nursing care situation and before starting with another resident, or when they were working by themselves such as while cleaning and washing. Both informal and formal interviews took on average 10 to 15 minutes, but varied between a couple of minutes and up to 30 minutes. The informal interviews with the residents occurred before, during, or after a nursing care situation or mealtime. In both units, the formal interviews were conducted in a separate small conference room or, with the residents, in their own rooms. Some of the nursing staff and residents did not want to be audio-recorded so the field notes for these interviews were made during the interview and written out as soon as possible after. The purpose of both formal and informal interviews was to clarify and explore the observations and to understand what the residents experienced in the observed situations and what the nursing staff's purpose and intention were for the care of the residents. The topics in the formal and informal interviews could be the same but, in the informal interviews, it was sometimes assumed a risk for other nursing staff, residents, or visitors to listen to what was being discussed and, in these situations, the researcher was more careful with questions and topics were more general and no names were used. The interview questions were related to the observed situations and questions posed to the residents were, for example, as follows: "How did you experience the situation?" and "What can make you feel a sense of well-being?" and questions posed to the nursing staff were, for example, as follows: "What was important for you in this situation?" "What did you enable in this situation?" and "Do you think this situation was about at-homeness for the resident?"

The first observations and interviews were regarded as an initial phase of the data generation whereby the observer could become familiar with the field and learn what to focus on to gain data relevant to the research aim. In this way, the first participant observations were more observing than participating and, when the researcher was more familiar with both the setting and what to focus on in the field, she was more involved in situations in the residents' rooms and closer to the actual nursing care situations. However, she continued to move between an observing and participating approach, which facilitated a reflective stance on situations in the field, the knowledge interest, and the way the data were generated in interactions between her, the participants, and the setting (cf. Friberg & Öhlen, 2010). During the fieldwork and the data analysis, the researcher read earlier studies on at-homeness, in particular those related to older people at the end of their life. In addition, some initial analysis of the observations was made during the fieldwork, which generated and influenced further participant observations and interviews to be able to gain a deeper understanding of how to enable at-homeness.

All data, that is, observations, formal and informal interviews, were analyzed according to a constant comparative analysis, which is an approach suggested in interpretive description (Thorne, 2016). The first author performed all the initial analyses with the help of critical comments by the other authors. First, the observation and interview data were read and listened to several times to gain a sense of the whole in the nursing care situations. Reflective notes were then written regarding possible interpretations of the observation data. Subsequently, the initial analysis of the observations was compared to interview data to deepen the interpretations or to propose refined, new, and/or alternative interpretations. While doing this, comparisons to the observation data and reflective notes were also made to further analyze for similarities and differences. During the analysis, the authors together validated the interpretations through critical and reflective discussions and through reading earlier research, as proposed by Thorne (2016).

Ethical Considerations

The Regional Ethical Review Board in Stockholm (2013/252-31/5 and 2014/1494-32) approved this study. Informed oral and written consent was obtained from the nursing staff and the residents before the observations and the interviews.

Written consent was predominantly used; oral informed consent was used when residents were no longer able to use a pen to sign the consent form. The participants were informed that their participation was voluntary and their confidentiality was assured, and that the participants had the right to withdraw from the study at any time without explanation. Due to the residents' frailty lives, and because their conditions could change from day to day, the observer ensured the participants' willingness to participate on a daily basis, and thus repeated informed consent was applied (Seymour & Ingleton, 2005).

Results

At-homeness for residents with life-limiting conditions in two nursing home settings was enabled in situations where the participating residents and nursing staff interacted and communicated. The observed situations were framed by some conditions. First, the residents' relatively short length of stay in the nursing homes presented a challenge in the care of the residents and made it particularly difficult for the nursing staff to get to know the residents' habits, preferences, and biographies well enough, which according to the staff sometimes made it difficult to enable at-homeness. Second, the palliative approach to the care provided to participating residents was mostly related to pain relief and nursing care responding to fundamental needs including safety, comfort, and support during toileting, dressing, eating and drinking, elimination, transfers, and maintaining social relations. Third, talk about death was seldom explicit, except for conversations with family members when a resident had signs of being close to death. Staff presented themselves as being open to talking about the prospect of death and loss in most of the situations observed. Explicit support concerning existential and spiritual needs was not observed, but was commented on by staff in informal interviews and during coffee breaks.

The results have been divided into five strategies of enabling at-homeness for residents and these could be regarded as strategies for nursing care; at-homeness is enabled through *nursing staff presenting themselves as reliable*, *respecting the resident's integrity*, *being responsive to the resident's needs*, *collaborating with the resident in decision-making*, and *nurturing comforting relationships*. These strategies are not separate from each other and, in the data, were often combined and occurred at the same time. The results show nursing care situations that could enable at-homeness; situations that did not enable at-homeness were observed but are not presented here as this was not the aim of the study.

At-Homeness Is Enabled Through Nursing Staff Presenting Themselves as Reliable

Ways in which the nursing staff behaved in nursing care situations and presented themselves to the resident as being

reliable were found to enable at-homeness. When the nursing staff appeared reliable, the residents felt that they were safe and could trust the nursing staff who took care of them. Being reliable in front of a resident was not just dependent on how long the nursing staff and the resident had known each other; it was more dependent on the ongoing encounter and the cues the nursing staff sent and how the residents responded. To be reliable meant that the nursing staff needed to be aware of how they behaved in relation to the residents and to be sensitive to changes if they noticed that the residents did not feel safe during the nursing care. The quote below shows how the nursing staffs' behavior affected the residents and illustrates what happened when one nursing assistant acted in an unreliable manner. This situation was initially understood as presenting a risk that the resident could experience homelessness, the opposite of at-homeness, but, after a change in behavior by the nursing assistant, the situation turned out to possibly enable at-homeness for the resident.

Staff: I create a sense of security through being secure in myself, for example, I was with a resident who had a CPAP machine and I was a little careful with how it worked, even though I actually knew how it worked, but my caution made the resident really worried and insecure and he started calling for help, "help can someone come and help me," even though I stood beside him. So I decided that I should tell him and show him that I knew how to use the machine. This calmed him down again. (Interview nursing assistant, short-term unit)

To present themselves to the resident as reliable, the nursing staff talked about the importance of obtaining information about the resident before meeting them, such as about the resident's health status, medical issues, and care plan from the records and through shift reports. This kind of background knowledge could be prerequisites that contribute to enabling at-homeness for the residents. This helped the nursing staff to be prepared and present themselves as reliable to the residents. Hence, the residents did not need to tell the staff all their details and feel stressed and afraid that something may go wrong during the nursing care situations.

At-Homeness Is Enabled Through Respecting the Resident's Integrity

Showing respect for the resident's integrity was interpreted as something that may enable at-homeness and also led to the residents experiencing safety and comfort. Ways of respecting the resident's integrity were by asking for permission to enter the resident's private sphere and, once given permission, by knocking or ringing a bell before entering the resident's room. Discussing with the resident about when and

how their care should be carried out was another way of showing respect for the resident's integrity. Another example occurred during nursing care situations when the nursing staff covered up the resident so that no more naked parts than necessary were visible. To exemplify this, both the field note and the quote below are from the same nursing care situation.

Observation: I am together with a nursing assistant and a resident who can no longer speak or express herself verbally, the nursing assistant starts washing the resident and talks to her the whole time, telling her what she is doing and what she is about to do. When we unbutton the resident's shirt, the nursing assistant puts a towel over the resident to cover her. The nursing assistant starts by washing and drying the resident's face, neck, chest, abdomen and hands. One part at a time. After finishing one part, the nursing assistant places a towel over the part that had been washed to cover the naked area so that not too much skin is visible. (Observation, short-term unit)

Interviewer: what was most important when you were with the resident today?

Nursing staff: When you are with the resident it is important to treat them with dignity. You have to think about how they want me to help them and to not show their nakedness for others, you have to think that you are a guest when you are with the resident. (Interview nursing assistant, short-term unit)

At-Homeness Is Enabled Through Being Responsive to the Resident's Needs

The interpretation that at-homeness is enabled through being responsive toward residents' needs is based on staff attitudes of being open-minded to the needs and desires expressed by or assumed to be present for the resident in care encounters. This was a strategy that the staff considered may have recognized and confirmed the residents' needs and helped in supporting the resident in their daily living in the way they wanted. This was in turn related to supporting the resident in being authentic and, through this, enabling at-homeness. The nursing staff was recognized as being responsive to changes in residents' needs such as when they were just days from death and could be struggling to communicate their needs. The nursing staff was sensitive to the resident's signals and let the resident be involved, for example, if they had pain or were thirsty or anxious. When the residents could have verbal or nonverbal communication with the nursing staff, they were also more able to let the residents be involved in their own care. This meant that the nursing staff "interpreted" the verbal and nonverbal cues of bodily and emotional conditions, the changes as well as the wishes of the residents, and that the nursing staff also wanted and acted in the best interests of the residents using the cues and wishes expressed.

The same nursing care situation could include elements of how to enable at-homeness and elements that did not enable at-homeness, experienced instead as homelessness. This is shown below in a quote from one nursing care situation where the nursing staff adapted to the resident's wishes (even though the nursing staff had not given pain medication before helping the resident). Here the observation situations and interview are from the same situation.

Observation: The nursing assistants come in to Katy, greet her and start preparing the wash, cloths and other things needed to take care of Katy. The nursing assistant asks her if she feels up to being washed and says that they are going to turn her. The nursing assistant asks her if she doesn't have too much pain. Katy says that she hasn't been given her pain relief tablets yet. The nursing assistant says that they can start by washing her face a little and do a few other things while the other nursing assistant goes and fetches the pain relief tablets. The nursing assistant starts washing Katy's face. She looks as if she is enjoying feeling the wash cloth on her face. Then the other nursing assistant comes back and says to Katy that she can take the tablets now and helps her with this. The nursing assistants ask Katy if she is up to being turned after taking her tablets. Katy doesn't think she is. Then the nursing assistants say that they will continue with other tasks like brushing her teeth and arranging the bed and the room until the tablets have started to take effect. (Observation, short-term unit)

Interviewer: What did you think about when taking care of Katy?

Nursing staff: When I took care of Katy she needed time, it took time to take care of her partly because she had so many requests and at the same time it was hard to take care of her because she had so many problems. So we planned in advance that when we were going to get her up we had plenty of time to take care of her. (Interview nursing assistant, short-term unit)

Being responsive to the resident's needs was, in many cases, expressed as something that was self-evident for the nursing staff and the basis for taking care of the resident. Being responsive was regarded as, for example, when the residents were still sleeping or did not want to eat just at that moment. The nursing staff let the residents decide and they planned together what would be best for the resident in every specific situation. If it was not possible to plan with the residents, the nursing staff evaluated the situation and acted based on what they thought would be best for the resident. Sometimes, the residents suddenly wanted to do things that they had not done for several days or weeks, for example, get out of bed and take a shower, which we can see from the field note and the quote from the same situation.

Observation: The nursing assistant goes into the resident called Isa and says “Good morning Isa.” Isa replies and then says that she wants to get up today. The nursing assistants ask her if she really wants to as she hasn’t been out of bed for two weeks. Yes, she does. They help Isa to the edge of the bed and she eagerly wants to start walking and doesn’t have time to put her anti-slip socks on. The nursing assistants then take Isa by her arms and help her to the bathroom, and she sits on the toilet. The nursing assistants wash her face and she says that it feels nice. (Observation, short-term unit)

Interviewer: How was the morning wash today?

Resident, Isa: It was lovely to get up and have a bit of a wash. It was so good and you (referring to the nursing staff) are so nice. (Interview resident, short-term unit)

This quote shows that the nursing staff was responsive to the resident’s wish even though initially they were not sure that it was a good idea for her to get up and take a shower. However, they did it for the resident and it turned out to be enjoyable. If the nursing staff is patient and let the resident decide where they want their morning wash, this may enable the experience of at-homeness.

At-Homeness Is Enabled Through Collaborating With the Resident in Decision-Making

Staff inviting residents to collaborate in decision-making is interpreted here as enabling at-homeness for the residents. This meant that residents were able to make active choices about themselves and their care. For example, residents collaborated in their own care in relation to food choices and mealtimes. If they did not want to eat the lunch that was served, they were able to choose something else that was easily prepared for the residents in the unit’s kitchen; the residents were able to choose what, how, and when they ate. Here, at-homeness is seen as being enabled through having the same food and mealtime patterns as in their own homes or wanting to eat just at that particular time, as the observation and quote from a same situation below shows.

Observation: The nursing assistant helps a female resident go to the dining room with her breakfast. The resident is tired and only takes a few spoonful of the egg she wanted for breakfast. The nursing assistant wonders if she wants something else. The resident then says “Yes, coffee and a biscuit would be nice!” “I’ll go and get that” then says the nursing assistant who asks the resident if she wants anything in her coffee. No, she doesn’t, she likes her coffee black. The nursing assistant asks if they should wait a little with the coffee if it is too hot? The resident then says that she likes hot coffee. The nursing assistant and the resident laugh together about that. The nursing assistant then wonders

if she should dunk the biscuit in the coffee, and the resident says she should. The nursing assistant then puts the dunked biscuit into the resident’s mouth and she eats a very little bit of the edge of the biscuit and says she would like some coffee which the nursing assistant helps her with as well as giving her a bit more biscuit. The resident then says that she doesn’t want any more and falls asleep almost immediately in her wheelchair. (Observation, short-term unit)

Nursing staff: I thought actually that it could be a bit of at-homeness to give her a biscuit with her coffee as this was maybe something she did in her own home and so why shouldn’t she be able to do it here, she has maybe always taken a biscuit with her coffee in her own home . . . When you think that she hadn’t eaten that much of her breakfast either then she ought to be able to eat a biscuit at breakfast. (Interview nursing assistant, short-term unit)

At-Homeness Is Enabled Through Nurturing Comforting Relationships

Relationships that were interpreted as enabling at-homeness were those between the nursing staff and the resident where the resident felt joy, safety, and closeness and was affirmed as being a person with, for example, preferences and history. One prerequisite for this kind of relationship was that the nursing staff visited the residents regularly, spent some time with them, and touched the residents both bodily and emotionally. This implied that the staff not only were knowledgeable about aspects of the resident’s biography and the present situation, but also communicated aspects of it which were then confirmed, modified, or rejected by the resident. This was interpreted as enabling at-homeness because it helped the residents to feel safe when they knew who was coming to them and when, and that the nursing staff spent some time with them, as the following quote illustrates.

Interviewer: What is it that gives you a sense of well-being?

Resident: It’s feeling secure, that’s important for me.

Interviewer: What makes you feel secure?

Resident: It’s all of you, that you are here and help me and sit here and hold my hand, but I’ve already said this to you all. (Interview resident, short-term unit)

Enabling at-homeness through striving for nurturing comforting relationships was interpreted as when the nursing staff discussed with the residents about their life, their family, the past, or the future and death. Sometimes, the discussions were related to everydayness as, for example, when the nursing staff asked about and discussed a cooking recipe with a resident who had talked about being interested in cooking or the nursing staff told stories from their own life during the nursing care, such as the observation here about

when a member of the nursing staff told the resident a story from her own life.

Observation: The nursing assistant goes in to Inga. She is lying on her bed and is having her incontinence pad changed. The nursing assistant talks to her slowly. At the end she combs Inga's hair and Inga says that it was so nice. Then the nursing assistant talks about her dog who loves being combed, and then about how her own hair always stood up and she had to comb it often. Both smile and it is a lovely time together, with a lovely feeling. (Observation, short-term unit)

Here a quote from a resident who talks about the care relationships and why she thinks it is important to discuss topics that matter to them.

Resident: It is a bit easier if you talk to each other and aren't just quiet, and that way you get to know each other in a different way. If you just talk about the weather then it gets a bit monotonous, the usual stuff. Then it's fun to hear about something else. (Interview resident, short-term unit)

Joking in sensitive ways was also interpreted as enabling at-homeness through striving for nurturing comforting relationships. Making a joke could be an initiative from both the nursing staff and the residents. Making jokes could have a bonding effect, contributing to nurturing comforting relationships and enabling relief from thoughts of illness and death. However, it had to be conducted in a sensitive manner and, if so, could encourage the residents to be themselves, as is exemplified below.

Observation: The nursing assistant showers the resident and in the shower the nursing assistant jokes about the resident seeing the physiotherapist in the afternoon and the resident says that the physiotherapist is a delightful man. The nursing assistant says that it is good then that the resident smells nice. Both laugh together at the joke. (Observation, short-term unit)

Also the quote from a resident illustrates the observation situation and confirms the importance of joking even at the end of life.

Resident: "Joking helps things along and so it doesn't get too gloomy but is instead more upbeat than downbeat." (Interview resident, short-term unit)

Discussion

The results from our study, the five strategies how nursing staff enable at-homeness, are supported by the participant observation study into at-homeness among older people by Edvardsson (2008) and suggest that nursing staff can help

older residents at the end of life to experience at-homeness through several strategies grounded in relationships where the resident and the resident's wishes and desires are respected. In our study, one strategy nursing staff used to enable at-homeness was through focusing on themselves and how they would be perceived by the residents; *at-homeness is enabled through nursing staff presenting themselves as reliable*. Another strategy that the nursing staff used was making the resident and the resident's needs the basis of the care of the resident. This was seen in the strategies: *respecting the resident's integrity, being responsive to the resident's needs, and collaborating with the resident in decision-making*. Finally, the nursing staff used a strategy where the relationships were focused on the connection between the nursing staff and the residents. This was regarded in the strategy *nurturing comforting relationships*. An earlier review of at-homeness in severe illness (Öhlen et al., 2014) pointed out that the experience of at-homeness among people with severe illness was related to being centered, being connected, and being safe. All these aspects of at-homeness could be dimensions that residents with life-limiting conditions may experience and the strategies that we have presented in this study could enable being centered, being safe, and being connected.

This study result has revealed strategies used by nursing home staff to enable at-homeness for older residents, both when they have had time to deepen the care relationship and when they previously have only had brief contact. To have had time to deepen the care relationship is similarly with earlier studies on at-homeness where time has been defined as a factor and if older people had more time to get used to a new life situation; this influenced the experience of at-homeness (Molony, 2010; Saarnio et al., 2018). However, to have had only brief contact with the resident and to manage enabling at-homeness is a new finding. One explanation of our results could be that at-homeness may be enabled in various kinds of care relationships depending on the staff's and the resident's personal approach (Proulx & Jacelon, 2004). Another explanation to manage enabling at-homeness in a brief contact could be the nursing staff's preparedness for taking care of residents who are at the end of their life, especially in the short-term nursing home, where the nursing staff had deliberately sought to work with people living close to death. Many of them had years of experience of taking care of dying patients which could be reasons why they seemed to emphasize ways of living in the situation.

Given that the aim was to study how at-homeness is enabled, we have no results related to how nursing staff could evoke feelings of homelessness for the residents. Rather, our results show that objectification and noninvolvement of a resident could be hindered when nursing staff are responsive to residents' needs, through collaborating in the decision-making with the residents and focusing on nurturing comforting relationships. Öhlen et al. (2014) found in their review that at-homeness and homelessness could be regarded as opposite poles where there was movement

between these poles, which in Rasmussen, Jansson, and Norberg's (2000) narrative interview study with patients cared for in a hospice was interpreted as a pendulum between a consoling and desolating hospice spirit; this could also be understood in our study as nursing staff having the power to enable at-homeness or evoke homelessness for the residents who are at the end of their life. Such fragility was vividly exemplified in a case study of an older woman with severe illness who moved from her own home to a nursing home and where experiences of homelessness could be related to an experience of being outside one's own distressed body that could persist if nursing staff did not involve the resident in their personal nursing care (Ekman et al., 2001).

The strategies disclosed may be understood as simple and obvious, both when we are thinking about nursing and palliative care in general and more specifically about how to enable at-homeness. However, care relationships have been recognized as being one of the fundamentals of care and moreover there has been recognition of problems with performing care where the focus is on the patient as a person in such relationships. Some of the problems identified have been related to a risk of depersonalized care (Kitson, Athlin, Conroy, & International Learning Collaborative, 2014). This can be understood as a need for staff being sensitive to suffering and fragility of the older person and receiving insight and wisdom from the other: a practical wisdom learned in encounters (see, for example, Kearney, 2000; Öhlén, 2002; Silfverberg, 1996). One attempt to create knowledge about the nursing staff–resident relationship that we think is in line with our results is compassionate-relationships-centered care which focuses on personal knowledge and conversations (Dewar & Kennedy, 2016; Dewar & Nolan, 2013). We also find this to be in line with Rasmussen et al.'s (2000) study that becoming at-home and hindering the risk of being metaphorically homeless midst dying could be supported by a consoling spirit among the staff and environment. Dewar and Kennedy (2016) found that care was experienced as excellent when nursing staff knew the older people and their specific wishes; this is similar to our results where being responsive to residents' needs and collaborating in decision-making with the residents were strategies to enable at-homeness. Another similarity with Dewar and Kennedy (2016) was that using jokes and humor was regarded as a strategy for making a connection which strengthens the person knowledge and which, in our study (jokes and humor), was interpreted as building nurturing comforting relationships which enabled at-homeness. Dewar and Kennedy (2016) also found that it was important that nursing staff did not assume that they knew what the residents wished and needed, which might be a problem when the residents are fragile and weak or not able to express themselves. In these cases, we believe that one strategy to enable at-homeness could be respecting the resident's integrity and continuing to be responsive to the wishes and needs that the nursing staff knew the residents had earlier. Another way could be to have

discussions with the resident's family about what they think the resident would wish and need, but this was not researched in this study.

We propose that our results could be understood as "strategies" that nursing staff may use to help the resident to experience at-homeness, but we also think that it is always the resident who ultimately defines if they are experiencing at-homeness or not. The results of our study could contribute to strategies for reaching the goal for palliative care of at-homeness (Dekkers, 2009). More specifically, it could be regarded strategies to safeguard a person-centered palliative approach in nursing homes. To realize the full capacity of staff, however, this might imply a need to redesign working roles and, for example, practicing a person-centered approach, as shown by McCormack, Roberts, Meyer, Morgan, and Boscart (2012), need to embrace the personhood of all persons involved, not only residents, also family members and staff in particular in the way relationships stand out in our result; then all involved need to be met as persons with or without the presence of residents. Special importance could be given to support nursing staff by managers and the organization (Bökberg, Behm, Wallerstedt, & Ahlström, 2019). Considering that the staff observed in this study was primarily nursing assistants, measures for registered nurses in nursing homes for how to support nursing assistants are needed, especially to create relationships and tailor nursing care actions focusing on the resident's personhood that take advantage of the remaining abilities and side-step restrictions in the environment (McGilton et al., 2012). However, the goals for palliative care cannot be reached without a combination of multidimensional strategies including timely symptom relief and family support. Moreover, given that at-homeness is considered an aspect of well-being, the strategies disclosed could be regarded congruent with a health-promoting perspective on palliative care (e.g., Kellehear, 1999), which is important indeed for people at old age cared for in what has turned into their habitual living spaces, aging in place in nursing homes and eventually to enable at-homeness among citizens who are living with life-limiting conditions and at the end of life. However, more investigations into how nursing staff could enable at-homeness are needed to confirm and develop at-homeness and understand how to enable it among residents in nursing homes. In a study on the readiness of nursing homes to implement palliative care, individual and organizational challenges were regarded as presenting difficulties in succeeding with the implementation of palliative care in nursing homes (Nilsen, Wallerstedt, Behm, & Ahlström, 2018). This shows the need for further development of palliative care in nursing homes and that implementation strategies of at-homeness as part of palliative care approach could face similar challenges. This is important to take into consideration if and when further studies on at-homeness and possible implementation projects in this area are planned.

Methodological Considerations

Credibility was ensured through the whole research process, mainly in relation to four principles, as suggested by Thorne (2016): epistemological integrity, representative credibility, analytic logic, and interpretive authority. Epistemological integrity was assured by following the design of interpretive description (Thorne, 2016) where all the research steps from the planning phase, the aim of data generation, and the analysis were continuously checked against the design.

Representative credibility could be a limitation of the study as there were only two nursing home units included in the study. However, the sample and the study context were chosen to gain rich participant observation data for in-depth interpretations and the variation in the situations observed could be regarded as more critical than the number of settings included. Residents who are living at the end of life are often vulnerable and we believe that there is a greater need to create security in the care settings related, which may take time to develop. One strength of the study might be the diversity between the nursing homes, long-term and short-term units, in two cities and with different orientation of care, as well as in different demographic areas. In addition, the staff had varied backgrounds and education.

Analytic logic was ensured from the beginning of the process of data construction. This was an ongoing process that started during the first observation period, where the interpretations and alternative interpretations of the data from the participant observations and the interviews were tested and used to guide the data generation further. Also the observer and the other authors of the study continuously discussed and reflected upon the situations that were observed, the role as observer, and the interpretations of the interviews and observed situations. This reflective approach guided the analysis of the situations observed, how and when the observer performed the participant observations as well as what was observed, all of which affected the data generation and analysis.

Finally, interpretive authority was facilitated using the field notes and quotes to support the interpretations and to make the interpretations of the observations transparent. One of the strengths of the study was that there were interviews from the observed situations that both directed the interpretations or gave alternative interpretations to the observations.

Qualitative empirical studies in the fields of nursing and palliative care are often based on interview data (cf., for example, Henoeh et al., 2016): This study, with both participant observations and interviews with the observed participants, contributes to the knowledge of how nursing care is enacted and practiced. One limitation of the study was that the residents' family members were not included in the field notes and the interviews. For future research based on participant observations, we therefore suggest also including residents' family members, which could facilitate the understanding of how staff and family together enable at-homeness for older residents in nursing homes. The results of this study imply that the strategies that have been

presented could be transferred to other similar contexts within Northern/Western societies—or at last to Nordic countries, where previous research into at-homeness primarily has been performed (Öhlen et al., 2014). One question for future research could be what other perspectives and phenomena at the end of life are important to take into consideration when nursing staff enable at-homeness. These could be, for example, spiritual and existential (religious and nonreligious) perspectives and the perspectives of significant others. In addition to this, to further the development of practice models for enabling at-homeness is merited.

Conclusion

Using a design of interpretive description by Thorne (2016) with participant observations, it was possible to reveal five strategies that enabled at-homeness for residents in nursing homes who were at the end of life. The results are consistent with a person-centered palliative approach and compassionate-relationships-centered care, and confirm the importance of care relationships when nursing staff enable at-homeness for the residents. Based on Dekkers (2009), the five strategies for how to enable at-homeness for residents in nursing homes who are at the end of life could form part of a palliative approach to nursing care for residents in nursing homes.

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