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FEATURE

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Influencing everyday activities in a nursing home setting: A call for ethical and responsive engagement

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This study focuses on influence that older adults, living in nursing homes, have over everyday activities. Everyday activities are key to sustain a sense of stability, predictability, and enjoyment in the local world of people's everyday and therefore a critical dimension of the person-centeredness framework applied within gerontology. This narrative ethnographic study aimed to shed light on how influence can be situated contextually, and how it can emerge through activities as well as how it is negotiated in everyday by frail older adults living in a nursing home. Residents, staff members, and significant others from one nursing home in an urban area of Sweden participated in this study. Data were gathered through fieldwork, including participant observation and formal and informal conversations during a period of 6 months. Data were analyzed through a narrative interpretative approach. The findings are presented in narrative form as exemplars. The exemplars—*Craquelures as justification, Seeking a place for other life worlds* and *An almost perfect trip*—reveal a gap between the client-centeredness framework and lived experiences regarding older adults' influence in everyday activities. The role of everyday activities in the context of frailty is discussed in terms of ethical and responsive engagement, and implications for health-care practices are considered.

KEYWORDS
ageing, dementia, frailty, health-care practices, narrative ethnography, narrative methods, person-centered, residential care, social poetics

1 | INTRODUCTION

During recent decades, there has been a clear policy focus on participation and influence in the health-care for frail older adults, both globally (Lyttle & Ryan, 2010; World Health Organization, 2002, 2012) and nationally (National Board of Health and Welfare, 2008, 2012; Official Reports of the Swedish Government, 2008). The ambition within these frameworks is to make health-care services responsive to individual needs and preferences by embedding influence to frail older adults in care practices. Care responsiveness toward older adults' needs, values, dignity, and personhood has been strived for multiple professional disciplines through the promotion of person-centeredness, a notion about what good care should be. This approach has its roots in a number of academic disciplines, practices, and socio-political movements (Leplege et al., 2007). Considerable contemporary contributions to person-centeredness emerge from disciplines such as dementia care research (Edvardsson, Fetherstonhaugh, & Nay, 2010; Edvardsson, Winblad, & Sandman, 2008; Kitwood, 1997), nursing research (McCance, McCormack, & Dewing, 2011; McCormack & McCance, 2006), and occupational therapy research (Hammell, 2015). Even though there is an overall consensus about the relevance of a person-centered perspective, it is in everyday care practices that the framework becomes more elusive and abstract, and a translation into practices is needed (Glasdam, Henriksen, Kjær, & Praestegaard, 2013; McCormack, 2004; McCormack, Dewing, & McCance, 2011; McCormack, Karlsson, Dewing, & Lerdal, 2010; McCormack & McCance, 2006; McCormack,

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Dewing, et al., 2010; Rahman, Applebaum, Schnelle, & Simmons, 2012). This is particularly true in nursing homes (NH), where the coexistence of disability, cognitive decline, and chronic conditions, often framed as frailty, challenge older adults' everyday life and the provision of care.

1.1 | Revisiting the concept of frailty

Frailty is an important condition to relate to in everyday practices in NHs. The term has been used in the literature over the last 20 years mostly as an emerging geriatric syndrome (Bergman et al., 2007) referring to a state of increased vulnerability to adverse events including mortality, morbidity, disability, hospitalization, and NH admission (Zaslavsky et al., 2013). This conceptualization is grounded in the understanding of the body as a homeostatic entity that gradually faces decline of physiological reserves (Karunananthan, Wolfson, Bergman, Béland, & Hogan, 2009; Zaslavsky et al., 2013). Thereby, the main focus on frailty research has been to find the constellation of biological indicators in order to prevent or delay the onset of frailty and disability, and it has lacked a more critical understanding of the assumptions between frailty, functional decline, and death (Grenier, 2007).

A philosophical understanding of frailty in this field aligns better with the relational stance proposed by the person-centered approach (Edvardsson, Varrailhon, & Edvardsson, 2014). Kristensson Uggla (2014) argues that the dominance of the principle of autonomy and an individualistic view has overshadowed vulnerability as one of the most central attributes of people as human beings. According to Kristensson Uggla (2014), this understanding touches upon the foundations of health-care disciplines, this means to engage with the one in need. This understanding of frailty as constitutional, also argued by philosophers such as Ricoeur (1992) and Levinas (2006), has lately been gaining more focus in gerontology (Björnsdóttir, Ceci, & Purkis, 2015; van der Meide, Olthuis, & Leget, 2015; Nortvedt, 2003). Furthermore, frailty understood as a condition for relational engagement (Ceci, Ttir, Björnsdóttir, & Purkis, 2013; Katz & Shotter, 1996; Kulick & Rydström, 2016) has been progressively explored in the literature regarding older adults living in NHs (Ebrahimi, Wilhelmson, Eklund, Dea Moore, & Jakobsson, 2013). Person-centered care research for frail older adults highlights as pivotal this relational dimension (McCormack, 2003, 2004; Nolan, Davies, Brown, Keady, & Nolan, 2004). More specifically, this framework makes explicit the need to move beyond technical competences and engage in the promotion of partnerships and collaborative practices with older adults (McCormack, 2004; McCormack & McCance, 2006). This relational perspective (Cardol, De Jong, & Ward, 2002; Nolan et al., 2004; Smebye & Kirkevold, 2013) also serves to counteract and problematize concepts such as autonomy, decision-making, and self-determination in person-centered care, which assign a central value to individualism and cognitive competences (Boyle, 2008).

1.2 | Everyday activities

The facilitation of meaningful activities and relationships that promote quality of life and thriving (Bergland & Kirkevold, 2006, 2008; Edvardsson, Petersson, Sjögren, Lindkvist, & Sandman, 2014; Edvardsson et al., 2017; Patomella, Sandman, Bergland, & Edvardsson, 2016; Zingmark, Sandman, & Norberg, 2002) is highlighted as a relevant dimension of person-centered care practices in NHs. There has been particular attention in research on the role and meaning that activities have for older adults living in NHs (Gustavsson, Liedberg, & Larsson Ranada, 2015; McCormack, Karlsson, et al., 2010, 2011; Van't Leven & Jonsson, 2002). Doing tasks, such as watering plants, doing laundry or setting the table, has been addressed as meaningful for older adults living in NHs (Edvardsson, Petersson, et al., 2014; Harnett, 2014). This knowledge about activities meaning for older adults is important, but limited because these tasks constitute just a small part of everyday activities in a NH. Moreover, they emerge mostly from institutional needs and are not necessarily grounded on the residents' interests (Benjamin, Rankin, Edwards, Ploeg, & Legault, 2016; Boelsma, Baur, Woelders, & Abma, 2014), which puts person-centered practices at stake. Spontaneous, unplanned, and unprompted activities that emerge through a relational and person-centered understanding of care are less often addressed in this research field (Harnett, 2010, 2014). In this sense, a broader exploration of the role and meaning of activities embedded in practices in NH settings is needed (Harnett, 2014) to narrow the gap between policy, national guidelines, research advances, and everyday practices (Edvardsson, Varrailhon, et al., 2014).

In this paper, we understand everyday activities as emerging and enacted in collaboration with others (Nyman, Josephsson, & Isaksson, 2014). This understanding is grounded in occupational science (Cutchin & Dickie, 2013), a discipline that critically explores the meaning and value of people's everyday activities. This view is in harmony with the relational perspective nursing research such as proposed by McCormack, Karlsson, et al. (2010). Occupational science understands everyday activities as a constellation of actions, facts, objects, and relationships that evolves and emerges from the immediate context (Cutchin & Dickie, 2013; Pichon-Rivière & Pampliega de Quiroga, 2012) and that are normally taken for granted or labeled as mundane (Hasselkus, 2011; Scott, 2009). Daily activities, structured and spontaneous, are particularly important to create and sustain a sense of stability, predictability, and enjoyment in the local world of people's everyday practices (Scott, 2009) and therefore a critical dimension of person-centeredness (Edvardsson, Petersson, et al., 2014, 2016; McCormack, 2004; McCormack et al., 2011).

We specifically focus our attention in this paper toward the limited influence older adults living in NHs have over everyday activities (Baur, Abma, Boelsma, & Woelders, 2013; Boelsma et al., 2014; Harnett, 2010; Holthe, Thorsen, & Josephsson, 2007; Persson & Wästerfors, 2009). The term influence, simply put as 'having a say in everyday matters of concern for the person' (Harnett, 2010), recognizes interdependence with others (Nolan et al., 2004; Wray, 2004) as a central aspect in the context of frail older adults' care. Harnett (2010) identified individual attempts to influence everyday practices performed by frail older adults in a NH. In her study, these attempts were described as either disrupting or matching the institutional culture of the NH. Even if these findings highlight the value of small-scale events pursued by frail older adults in NHs, it remains unclear how influence is enacted and negotiated in everyday activities.

Tensions and challenges about how older adults living in NHs enact influence have been highlighted in research by Persson and Wästerfors (2009); staff members experienced that they paid more attention to institutional efficiency (e.g., registering care actions) than to supporting opportunities for residents to influence everyday activities. Boelsma et al. (2014) highlight the importance of paying attention to 'small things', in order to achieve alignment between institutional' needs and residents' values and preferences. Their study showed that care staff frequently considers 'small things', such as mealtime situations and group activities, as insignificant or trivial when compared to institutional routines. Important knowledge about the predominance of institutional routines emerged from Goffman's work (1961) about 'total institutions' and specifically about NHs nationally (Öhlander, 1996; Salzmann-Erikson, 2016) and internationally (Gubrium, 1975). These ethnographic studies show how institutional rulings have been enforced, often at the expense of people's identity and well-being in the past and in a context characterized by frailty. The historical context of our study, in contrast, is immersed in a policy framework that promotes participation and person-centeredness. In this framework, there is a claim for a new type of logic, a culture change in care that includes accommodating to the unique needs of frail older adults, rather than practices determined in advance (Ceci, Purkis, & Björnsdóttir, 2013; Roberts, 2016). However, there is limited knowledge about how influence enactment is unfolded in everyday practices.

This study aimed to bring light on how influence can be situated contextually, and how it can emerge and be negotiated through everyday activities by frail older adults living in a NH.

The main research questions are as follows:

- How do frail older adults exert influence in everyday activities in a nursing home setting?
- What are the conditions that facilitate or hinder frail older adults to exert and negotiate influence in a nursing home setting?

2 | METHODS

2.1 | Study design

Epistemologically, this study is situated in a hermeneutic tradition (Kinsella, 2006). A narrative ethnography (Gubrium & Holstein, 2010) was used, and data were gathered during a period of six months.

2.2 | Research context

This study was conducted in an urban area of Sweden. The NH, managed by the municipality, had a total capacity for about 200 residents. The specific unit at the NH involved in this study had a capacity for 54 residents living there. The building had three floors, one of which was profiled for people diagnosed with dementia. The two other floors were open for old persons with a variety of diagnoses. Each floor had a capacity for 18 residents and was divided into two wings. Each wing had two corridors with four, respectively, five flats. These flats were about 20 m^2 and were rented by the residents. Each flat consisted of one room with a small pantry and a toilet/shower area. The rooms were spacious and bright, had room for a clinical bed and some personal furniture that the residents brought from their homes when they moved in.

In each wing, there were three common areas used both by staff and by residents: a meal area, a small living room, and a kitchen. All wings looked alike, except for the wall color and slightly different decorations. The residents could move from one wing to another (with different levels of assistance). Doors to the elevators/main stairs of the building, to other floors, balconies, and to outside areas were locked and alarmed. To get in and out, an electronic key and a code were needed, and neither residents nor significant others were provided with these items. This meant that mobility within the NH was restricted to the floor on which the person was living. In order to go out or to go to another part of the building, the resident would need to be accompanied by a staff member.

During day shifts, two registered nurses were responsible for the total number of residents. At night, staffing decreased to from five to one nurse assistant for each floor and one registered nurse for the total number of residents. Nurse assistants, who in some cases had 1 or 2 years of high school education and diverse work experience at NHs, were most frequently in interaction with the residents. Physiotherapists, occupational therapists, and a geriatrician visited following a pre-established schedule and had individual plans for the residents. The occupational therapists' focus was on the prescription of assistive devices, adaptations in the residents' flats, and organization of the group activities that took place once a month. The nurse assistants supported the majority of the residents in activities of daily living.

The residents' daily life at the NH included meal routines, medication, and hygiene. It also included a scheduled group activity once a week. Residents from the same floor would gather together for about one and a half hour to participate in bingo, memory games, and songs. Aside from these activities, the place was characterized by passivity and silence among the residents. This dynamic was sometimes broken by small talks between residents and the nurse assistants, significant others (e.g., spouses, children, or friends) visiting the residents, or by other activities (e.g., gymnastics with a ball, reading the newspaper, TV on) carried out sporadically by the nurse assistants.

2.3 | Key informants

To study how influence can be situated contextually, emerges through activities, and is negotiated, diverse activities and situations involving the residents were approached using ethnographic methods including, informal and formal conversations, archival material, and participant observation (Emerson, Fretz, & Shaw, 2001). Participant observations included activities performed by staff, significant others, and administrative personnel as part of the residents' social life and context.

The residents' age ranged between 74 and 103 years, and the length of stay was between 2 weeks and 5 years. The residents had multiple chronic conditions (e.g., diabetes, hearing impairments,

cardiovascular conditions, limited mobility) and different levels of cognitive decline including dementia diseases. The majority of them used a wheelchair or a walker.

2.4 | Data gathering

The primary researcher (MM) initially spent 2–3 days a week getting to know the residents, the place, and the staff; this fieldwork continued at the different units engaging progressively with various residents in everyday situations. The researcher positioned herself as a frequent guest at the NH, applying reflexivity (Finlay & Gough, 2003) over the situations unfolded in everyday situations and actively engaging with the participants. Reflexivity here is understood as the critical self-reflection on the researcher values and preunderstandings as a part of the context (Finlay & Gough, 2003). The fieldwork also included meetings with significant others and staff meetings when access was permitted. The last author (LR) spent time at the institution, initially once a week, meeting both residents in everyday situations and staff members to introduce the project.

Situations were selected purposively, based on the residents' social activities that had rich observational potential. These situations evolved over time and were, for example, waiting for a mealtime, preparing for the weekly activity or monthly entertainment activity, a visit by a significant other, or just passing time. Progressively, the residents invited the first author to their flats. Participant observation also took place in daily clinical staff meetings and in the monthly information meetings for significant others. Participant observations (Emerson et al., 2001) and conversations during the fieldwork period were used as the main source of data. Fieldwork was conducted regularly, 5 hr each day, varying between day and night shifts, different hours during the day, some weekends, and some holidays. Participant observations were conducted on different floors with the ambition to explore a broad range of everyday activities with diverse residents. The observed activities were sometimes planned ahead but mostly decided in the moment and in the course of interaction with residents and staff.

The data gathering approach was inspired by the practice of social poetics (Katz & Alegria, 2009; Katz, Conant, Inui, Baron, & Bor, 2000; Katz & Mishler, 2003; Katz & Shotter, 1996) which seeks to grasp what is happening in front of our eyes in living and situated moments and by paying attention to 'mundane' activities. The first author paid extensive attention to situations unfolding in everyday life that were assessed as interesting, problematic, ambiguous, or key to acknowledge the research question. Particular attention was given to noting *striking events* (Katz & Alegria, 2009) or what was also called *significant events* by Mattingly (1998) revealed through emerging situations in everyday life. These moments made visible what was at stake for the residents. Certain reflexive questions allowed the researcher to look further into otherwise overlooked situations (e.g., what is happening in the situation?). This inquiry-guided approach incorporated the researcher as an additional resource, taking advantage of the researcher's situatedness (Emerson et al., 2001; Stoetzler & Yuval-Davis, 2002). By doing this, attention was paid to the experiences in the interpersonal realm, comprising thoughts, feelings, and emotions. When a session of participant observation was finished, the first author recorded voice memos, registering significant moments of the day. Extended field notes were made based on the preliminary field notes and voice memos. Striking events were the analytical point of departure. These were operationalized by the guiding question of 'what stays with me today?' Debriefing analytical sessions (e.g., overviewing the day or outlining striking moments) were conducted immediately after fieldwork when the first and last author spent time together in the NH. The total of field notes written during the fieldwork constituted the field note corpus (Emerson et al., 2001).

2.5 | Data analysis

Data were analyzed guided by a narrative method grounded in Polkinghorne (1995). The analysis comprised three analytical levels: field notes corpus (Emerson et al., 2001), vignettes, and exemplars. For a preliminary analysis, segments of the field notes that stood out as *striking events* (Katz & Alegria, 2009) were highlighted and selected right after a day of fieldwork (first analytic text). As a result, new questions were written down to guide the forthcoming observations at the NH. In the next step, the written segments were transformed into a short narrative account with a tentative analysis, a *vignette* (second analytic text), which functioned as a starting point for a deeper analysis together with the co-authors. Each *vignette* was a preliminary emplotment of the striking events; this means the events were placed within a meaning context. Each *vignette* was then further analyzed and developed in search of possible interpretations. In this step, the emerging data were put into dialogue with theoretical resources about, for example, influence, frailty, and everyday activities in NHs, to identify new knowledge and alternative interpretations. According to an excerpt strategy (Emerson et al., 2001), from all *vignettes* that emerged from the fieldwork and analysis, a set of narrative exemplars (Emerson et al., 2001; Frank, 2010; Katz & Mishler, 2003; Mishler, 1990) was selected and further interpreted. The exemplars selected resonate most closely with the narratives encountered during the fieldwork. These exemplars are integrated texts of field notes and interpretation, highlighted because they make explicit a dialogue of multiple views of the social actors involved in everyday activities at the NH. The set of exemplars unveil recognizable situations from the local practices of the NH setting and tensions that are relevant to the research inquiry and give hopefully the reader the possibility to identify issues at stake at the NH. The exemplars had the function of being points of reference that allow the reader a nuanced and complementary understanding of influence enactment at the NH.

An iterative hermeneutic process (Frank, 2010; Josephsson & Alsaker, 2015; Polkinghorne, 1995) and regular analytical discussions for validity (Polkinghorne, 2007) characterized the whole analytical phase, including a dialogical juxtaposition (Katz & Mishler, 2003) between the gathered data, emerging findings, and theoretical resources about the research topic.

2.6 | Ethical considerations

Ethical approval was obtained from the local ethical committee in Stockholm prior to data collection. Staff, significant others, and residents

were informed both verbally and in writing about the research project, and they were invited to participate. Consent and data collection were adapted to the specific setting, through visual aids, informing the residents in the company of a relative, or by repeating the purpose of the study at each encounter if necessary. Respect for the participants' integrity was central at each stage during the fieldwork. The researcher continually asked and assessed if the residents, and other actors, expressed verbally or with body language, the willingness to participate in the study. The researcher did not confront participants who did not want to take part, and joined in only with those who seemed to invite the first author to participate. As ethnography consists of an extended period of time in the setting, therefore relationships with the researcher and the participants were developed. To express respect for those relationships, the process on ending this phase of the study was carefully planned and communicated with the participants (Murphy & Dingwall, 2001). Pseudonyms are used to reassure anonymity of the participants.

2.7 | Findings

The findings of this study are presented as a set of exemplars. Together these exemplars aim to provide a nuanced perspective about how influence is situated contextually, emerges through activities, and is negotiated by frail older adults living in a NH. Three narrative exemplars are presented as follows: '*Craquelures*'[1] *as justification, Seeking a place for other life worlds,* and *An almost perfect trip.* The exemplars are grounded in observational data and informal conversations from the fieldwork.

2.8 | 'Craquelures' as justification

The following story is composed of several observed events that have been assembled together. The metaphor of 'Craquelures' emerged from the data and was identified as being central in these findings and will be further explored in the discussion. '*Craquelures*', or an entangled network of cracks, is understood in these findings as representing a quality of discontinuity and disruption between participation and person-centeredness policies, everyday activities, and practices in a NH and a gap between policy and experiences.

An afternoon in the winter, the primary researcher came into the dining room and found Margot, an 87-year-old resident, sitting in her wheelchair with an angry expression on her face: 'I have been waiting and waiting here for a long time now; I have pressed this (showing her bracelet alarm) and still no one is coming!' The primary researcher responded by asking what she needed: 'I have a horrible pain in my back and I want to lie down in my bed just for a while. I know it is early, but it is the only way the pain calms down!' At this moment, she started to reflect out loud on her anger in a deeper sense: 'You know it is this indifference that hurts! Nobody coming feels the same as someone doing this to a wound (to show her pain, she forcefully pressed and twisted her right hand index finger into her left palm)'. The primary researcher informed the nurse assistant on duty (who was by then busy with the laundry) about Margot's situation; the primary researcher wheeled Margot to her room, talked, and waited together for more than an hour, without any response from the staff on duty.

The involvement of the nurse assistant with other duties at the expense of Margot's needs in this situation could be seen as amplifying Margot's dependent position and creating a greater distress. This serious situation, to ignore Margot's needs, could be understood as tacitly allowed by the NH culture, creating a disruption between ethical engagement and person-centered care.

In another occasion during the fieldwork, the primary researcher was talking with one of the managers about the staffs' duties toward the residents. The manager bitterly expressed about how fragmented the staff was 'This staff is cracked;[2] they have been through many changes the last couple of years!' She used the expression of '*cracked*' in the sense of damaged, conflicted, and falling apart and reflected on this as a way of explaining the lack of engagement from the nurse assistants toward the residents' needs. She further explained that during the last 5 years, the nurse assistant group had been through many changes in their job description and their identity had been changing along with the change of policies, administration, and financing of elderly care. Further, she described the nursing assistant group as 'resentful' and understood this as an expression of the struggles faced by them in their everyday practices. She suggested that the many tasks besides caring duties split the staff's focus on account of additional new functions such as cleaning, documenting, and different administrative tasks to be done by the same or even less staff in a constricted timeframe. The manager seemed to understand this 'cracking' as a process of disintegration experienced by the nurse assistants as a group. To her, this process was explained partially by the staffs' struggles to engage and support influence in everyday practices related to the residents.

A similar dimension of this stance was identified at one occasion in the beginning of a get-together meeting for significant others of the residents at the NH, but this time it came from one of the nurse assistants. Just before formally starting the meeting, she said to those assembled: 'It is really a pity that we have so many new tasks that are not about caring for the residents, but are instead about taking responsibility for administrative things and new routines like ordering food or writing rapports and so forth. We don't then have the time to focus on what we used to do before and what we are here for'. Surprisingly, in this meeting, none of the significant others present showed a visibly negative reaction to this statement, nobody asked or said anything further on the topic; instead, they seemed to accept it as a natural explanation.

As could be seen in this exemplar, neglecting the residents' emergent needs in everyday activities put the residents' integrity and opportunities to have a real influence at risk recurrently. The staff's prioritizing of other institutional routines represents a moral dilemma that has an impact on the residents' influence. On the one hand, staffs need to fulfill job duties, all of them, even those indirectly related with the residents. On the other hand, staffs are bound to provide attentive

[1]Craquelures: comes from the world of art and has as such particular aspects, cracked texture. 'Cracks' are due to stress and aging, exposing several layers, and disruption of a wholeness.

[2]Word used in Swedish was *krakelerad*, which in everyday language means cracked in the sense of damaged, with lines on the surface from having split without coming apart.

care to emergent needs of the residents. It becomes problematic if the priority on duties is at the expense of the residents' needs, which embody restricted power and influence possibilities. It is also problematic if the institutional culture and leadership justifies or validates these types of practices.

2.9 | Seeking a place for other life worlds

One afternoon the primary researcher was waiting for the monthly 'Entertainment' activity, as it was called at the NH, together with some of the residents. This was one of the regular structured social activities of the NH. There was no intent from the leadership to tune or co-design these or other activities with the residents. There was a clear focus to do it for the residents instead. External professional singers came to the NH and performed for 1 hr. These visits were something that seemed to be appreciated by some of the residents; it gave the day a new dynamic with new faces coming in and musical instruments brought into the NH. The staff seemed stressed in this particular activity bringing people into the room and hurrying to get residents from all floors. Some residents waited for almost 1 hr before the performance started. Some of them became uneasy, asking questions or looking puzzled, and others just waited quietly. The primary researcher took the opportunity to gather some impressions from the residents about this waiting time before the performance. One lady, Sara, caught my attention; she was new at the NH and had moved in just a month before. The primary researcher had talked very briefly with her before, and on those occasions, she had appeared to me to be very insightful. She was almost blind and was sitting alone in the first line of chairs. The primary researcher sat at her side, and she noticed my presence. She was very neatly dressed, and I commented on that. Sara answered 'Well you know after working your whole life as a secretary, it is just a habit to do so'. Her comment spurred the primary researcher to keep talking to her. Sara opened up with ease around diverse phases in her life. She shared many details about her life before coming to the NH, for example that she was single and did not have any children and that she was strongly involved in a church choir before she started living at the NH. She also let me know that she was satisfied with her life. She surprised the primary researcher by telling very calmly 'I can go in peace now, you know. I have already decided in which church I want to have my (funeral) ceremony, what kind of flowers I would like to have and even the songs'. The primary researcher continued listening to her and noticed that this topic was somehow settling for her and that she was comfortable talking about it. Meanwhile, the staff continued to wheel or walk in residents to the room for the performance. Some residents became uncomfortable after waiting so long, or for not having more information about what was going to happen. The staff struggled to attend to all these diverse needs, trying to calm residents. At this point, the musical performers were about to start. Suddenly, Sara grabbed the primary researcher's arm and brought it forcefully toward her chest and whispered 'It is this last part of life that I don't understand'. A couple of minutes later, the musical performance began, Sara started to listen to the music, and the conversation ended.

This exemplar could be interpreted as showing a deeper quality of everyday life activities, the elicitation of multiple life worlds. It becomes clear that Sara's story at the NH is part of a bigger story. Sara's engagement in conversation with the primary researcher opened momentarily the possibility to talk about her multiple life worlds (Gubrium, 1975), such as her background as a secretary and even her contemplation of death, life worlds that would pass unseen without engagement. It also seems difficult for Sara to situate this new form of life at the NH, which does not have precedents. Everyday life activities, arranged mostly by others, seem difficult to be situated; she has no ownership on them and could be seen as challenging influence enactment. In this sense, Sara's exemplar could also be seen as making visible a certain disruption of her identity due to the institutional culture. Everyday life activities, which are planned without consulting her interests and leaving unaddressed relevant aspects of her identity, do not necessarily contribute with a sense of continuity for Sara. This context offers predominantly passive roles (such as to be taken care of, entertained, or invited into tasks). Other aspects of Sara's repertoires, closer to her interests and abilities, are less acknowledged.

2.10 | An almost perfect trip

Catherine, an 82-year-old woman, told me about the progressive advance of her Parkinson's shortly after we met for the first time. This way of introducing herself, foregrounding her diagnosis, attracted my interest in her and situations she could be facing. After this, the primary researcher met her several times during the fieldwork period.

The following event took place right after lunch in the dining area at the NH. I was sitting beside Catherine, talking about what she was interested in doing. She told the primary researcher that she liked reading books, but had difficulties in seeing now and therefore did not read any longer. She told about some of her favorite authors and added 'Just imagine having the chance to go into bed on a rainy day listening to a good book!' The conversation went on and she continued 'You know, I have so lite energy. It even varies from one day to another or even during the same day. Yesterday I went for a trip by car to the other side of the city. I had a dentist appointment at X hospital. I have been in many hospitals, but I hadn't been there before. It was fun to see the city, to see how things change! The hospital was very modern and clean, and the staff was really nice. They explained to me everything they were going to do!' I was surprised of the meaning the dentist visit had to her. Catherine continued 'It would have been perfect if we (she and a nurse assistant) could have stopped just for a little while to have a fika[3] afterwards. But the staff told me that there wasn't anything nearby'. The primary researcher asked her 'When do you have to go back there?' '*I don't know*', she answered.

This exemplar could be understood as another dimension of the residents' limited possibility to enact influence and to engage in spontaneous activities *within* and *in between* structured activities. It also shows how ephemeral and situational these moments could be in everyday practices. The event of traveling outside the institution

[3]*Fika* is a concept in Swedish culture with the basic meaning of having coffee together with someone, often accompanied by pastries: a shared quality moment.

through the changing city, to be physically in other places, and to be met differently than the usual way could be understood as a valued event per se. Catherine experienced this event as contrasting to her day-to-day reality. Furthermore, the set of events as they unraveled during her dentist visit could be understood as a preparatory preamble for her to dare to propose the *fika* afterward.

Catherine's attempt to enact influence could also be understood as a desire to shift from the institutionally assigned fixed role of a patient toward the role of a person, foregrounding instead space for spontaneity, flexibility, and real influence in favor of a more pleasing day. As expressed by Catherine, the mood to engage in something desirable is experienced as unreliable for her, because of the uncertainty of the occurrence of such events and because of her labile energy. Catherine's recollection of the dentist visit could be seen as a request to give relevance to small-scale events in a given situation, as the missing *fika* in this story, for a valued everyday where influence could be enacted.

3 | DISCUSSION

The aim of this study was to reveal how influence is situated contextually, emerges through activities, and is negotiated in everyday activities by frail older adults living in a NH. The findings point toward the urgent need to redefine frailty beyond the medical paradigm and rather as a demand for responsive and ethical engagement. The discussion will be organized to illuminate the overlooked value of everyday activities as a crucial arena for influence enactment and client-centeredness in the context of NHs. Furthermore, we discuss the gap between ideology and experiences expressed as discontinuity and disruption between person-centeredness policies and everyday activities in a NH.

3.1 | Everyday activities: a crucial arena for influence enactment and person-centeredness

The findings of this study contribute to new understanding of the meaning of everyday activities in an institutional setting, experienced by residents of a NH. These findings suggest that everyday activities in NHs could have an amplified relevance, beyond something being provided or solely understood as tasks. This amplified relevance is illustrated in the exemplar *An almost perfect trip*, exemplar where the opportunities for the resident to enact influence could be seen as emerging and unfolding during her visit to the dentist. It could also be seen at the exemplar *Seeking for a place for other life worlds*, where everyday life activities elicit the surfacing of other life worlds. In the first case, the positive experience during the dentist visit could be seen as changing her own embodied perception of the situation and giving her the courage to propose the *fika.* Her attempt, however, did not succeed, and person-centered care could be understood as challenged. From the institutional perspective, the whole situation in *An almost perfect trip* might be unproblematic, since the requirement of the dentist appointment was fulfilled. One explanation for this logic could be that the staff is immersed in the traditional understanding of care, in which procedures have a given order, sequence, and structure. It is then not easy to make space to the resident and her emerged logic.

In the second exemplar *Seeking for a place for other life worlds*, the fragmentation of everyday activities as a whole is striking. The foregrounding of scheduled activities might risk overlooking residents' coexisting life worlds. While understanding that routines are necessary to provide care services in a secure way, other types of situations and practices as sources of meaning are less addressed. This reasoning is in line with findings of other studies in NH settings (Boelsma et al., 2014; Gubrium, 1975; Harnett, 2010, 2014; Öhlander, 1996; Persson & Wästerfors, 2009), where the coexistence of diverse life worlds might be concealed due to institutional routines. Furthermore, the exemplar *Seeking for a place for other life worlds* could be understood as threatening the resident's identity, due to limited influence and ownership over her everyday life. Identity maintenance through everyday activities has been identified as key in person-centered approach (McCormack, 2004; Zingmark et al., 2002).

The findings of our study show that this deeper meaning of everyday activities could remain invisible to the staff representing the institutional routines. This confirms previous research findings suggesting that these types of co-operation relationships are not self-evident in the context of NHs (Baur et al., 2013; Smebye & Kirkevold, 2013). It can be argued that Catherine's experience of attempting to suggest a *fika* might set a precedent for future similar situations. By assuming that, she cannot make spontaneous attempts and she might be embodying the institutional order and giving up on her hope to influence everyday practices. In this sense, there is a risk that she could progressively give up a sense of ownership and sovereignty (Frank, 2013) of her everyday life activities. In the second case, the risk is the invisibility of other life worlds.

3.2 | 'Craquelures': frailty demanding responsive and ethical engagement

Frailty and dependency are central conditions to be acknowledged in this context of a NH. In this sense, frailty adopts a new character, as a demand for responsive and ethical engagement. This engagement is seen as responsive in the meaning that is aligned with the limitations and resources of older adults. It is ethical in the sense that acknowledges the relevance of activities in this phase of life and context. This engagement, as revealed in the exemplars, could be enacted through small-scale events within everyday activities, adding the *acting* dimension to care The understanding of influence illuminated in this study differs from conceptualizations of autonomy and decision-making grounded in individualism, proposing a relational and *acting* understanding instead (Abma & Baur, 2015; Baur et al., 2013; Cardol et al., 2002; Ceci, Ttir, et al., 2013; Katz & Alegria, 2009; Nolan et al., 2004).

'Craquelures', understood here as a disruption in person-centered care practices, could be seen in the exemplar of the woman waiting for relief to her back pain: *'I know it is early [to go to bed]'*, she said. By saying this, she recognizes the institutional routines and that her request is out of the ordinary, and might cause trouble. This highly embodied awareness of the place, the NH culture, and its dynamic

does not inhibit her from asking for an exception to the rule. She relies on the nurse assistant's responsive action that will help her to relieve her pain. In this case, the omission of engagement embodies disempowerment on the resident in a disciplinary institutional culture (Salzmann-Erikson, 2016). As argued by Kleinman (2006), it is the orchestration of all the little things together that constitutes care-giving, which is line with our findings.

As exemplified above, frailty becomes a demand for engagement and this will require a certain degree of readiness among the staff to read, assess, and act on a given situation. These will need an appreciation of the potential of emergent situations, a logic of engagement by acting beyond the routines. This readiness to engage is also at stake at the exemplar where the old lady states, '*not understanding this last part of her life*'. This lack of cues could be seen as a call for further help. What can I do here? Would you explain this to me? Could you guide me through it? This could be seen then as another dimension of frailty, of reaching out for dialogue and connection enacted by the residents. Existential issues at risk of passing by unseen could gain a time and a place, through engagement. In this sense, it seems to be important to address that what happens *during* and *in between* activities could also be important aspects of coexisting life worlds (Öhlander, 1996). This line of reasoning suggests an understanding of interdependence as a central condition (Frank, 2010; Nolan et al., 2004; Smebye & Kirkevold, 2013) when working with frail older adults. Frailty and interdependence, understood as a demand for engagement, as a part of the human condition (Kristensson Uggla, 2014; Levinas, 2006), and unfolding through these small-scale actions, can possibly create arenas for influence enactment. Embracing these openings provided by frailty in everyday activities could eventually help to deflect traditional power positions enacted in NHs. Such approach toward the residents would require profound philosophical and practical changes in the institutional culture of care of frail older adults.

3.3 | Situating everyday activities in context

The challenges faced by staff members and residents are in part consequences of an institutional culture embedded in a major health-care system transformation in Sweden (Magnussen, Vrangbaek, & Saltman, 2009; Perkins, Ball, Whittington, & Hollingsworth, 2012). The challenges seem to reside in finding ways to tune everyday demands in practice in accordance with values that match the local policy framework of person-centered care and make services responsive to frail older adults.

'Craquelures' as justification exemplar presents this conflicting stance; ambivalence and disruption are manifested by staff members caught between care activities and new tasks imposed by structural changes as addressed by other studies (Ball, Lepore, Perkins, Hollingsworth, & Sweatman, 2009). This dilemma could be seen, for example, by the nurse assistant of not doing '*what we are here for*' in the sense of providing responsive care to the residents. Lack of time and short staffing (Benjamin et al., 2016; Gustavsson, et al., 2015; Salzmann-Erikson, 2016; Stabell, Eide, Solheim, Solberg, & Rustøen, 2004) are examples of organizational conditions hindering influence enactment in everyday activities. These dilemmas can be seen as being understood and accepted to different degrees by all parties involved as follows: management staff, significant others, and even the residents. In this sense, the NH community accepted disengagement in immediate needs of the residents and inhibiting residents' influence on everyday matters. However, this disengagement creates fissures that antagonize bonding and trusting relationships of key relevance within a person-centered approach (McCormack, Karlsson, et al., 2010). Spontaneous activities emerging from the everyday, such as time for a spontaneous *fika* or time to rest even if is outside the routines, could be seen as challenging the translation into practice of the local policies concerned with individuals influence and person-centered practices (McCance et al., 2011; McCormack, 2004; Government Offices of Sweden, 1998/99; National Board of Health and Welfare, 2008). Furthermore, these dilemmas could be seen as showing what is missing in the culture of care, the need for attention toward everyday life as whole for older adults.

3.4 | Limitations of the study

The presentation of the findings in complementing exemplars may be untraditional; however, this choice was made based on the assumption that human experiences are often complex and intertwined (Frank, 2010). We also acknowledged that this study represents practices and experiences from a limited setting, and further research is needed to further delineate the elusive concept of person-centered care and its relationship with influence enactment. However, even if the presented exemplars are local, it does not mean their significance is local.

4 | CONCLUSION

Our findings suggest that everyday life activities in the context of a NH have an amplified meaning and pivotal role and could be considered a chance for responsive and ethical engagement. This study proposes a perspective in which frailty is seen as a demand to bond, connect, ignite collaborative practices, and social participation (Abbott, Fisk, & Forward, 2000) through engaging and acting in order to embrace the conditions of frail older adults. Influence in everyday activities, a central aspect of person-centered care, is not necessarily exercised in a direct and outspoken manner, as exemplified in the findings; consequently, professionals have to actively look and act upon it.

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