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Meaning in life of older adults in daily care: A qualitative analysis of participant observations of home nursing visits

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Abstract

Aim: To explore situations in daily home nursing regarding meaning in life of older adults.

Design: Qualitative research design.

Methods: In total, 197 participant observations were conducted during home nursing visits between September 2015–May 2018. Descriptions were thematically analysed. The themes of this analysis were subsequently linked to dimensions of meaning in life. Dialogue in research groups expanded understanding.

Results/Findings: Four main themes were found namely: being in a private environment; nurse–patient encounter embedded in a relationship; personal care; and conversation.

Conclusion: Meaning in life of older adults may come to light in every situation during daily care. Hence there are many opportunities for nurses to attune their work to patients' meaning in life. Nurse education and health management should enable them to do so.

KEYWORDS
care quality, home nursing, meaning in life, nurse–patient relationship, nursing education, older adults, participant observation, quality of life, spirituality, well-being

1 | INTRODUCTION

People generally strive to live meaningful lives. In recent years, the concept of meaning in life (MIL) internationally has gained attention in society and in healthcare settings. MIL is considered pivotal for 'a good life' (Collin & King, 2004; Derkx, 2011, 2015; Esfahani Smith, 2017). MIL is important for nurses because of its positive association with health (Huber, van Vliet, Giezenberg, & Knottnerus, 2013; Ryff, 2012; Steger, 2012), well-being (Steger, 2012; Westerhof, Thisen, Dittmann-Kohli, & Stevens, 2006), and quality of life (Haugan, 2013; Pitkala, Laakkonen, Strandberg, & Tilvis, 2004). However, MIL is not only a means to an end, it is important on its own merits (Derkx, 2011; Esfahani Smith, 2017).

1.1 | Background

For many people, MIL is not a common subject. It may entail something different for every single person (Frankl, 1959). MIL is a

comprehensive dynamic construct, as the description of Brandstätter Baumann, Borasio and Fegg explains:

> 'Meaning in life is a highly individual perception, understanding or belief about one's own life and activities and the value and importance ascribed to them. Meaning and purpose are related to terms like order, fairness, coherence, values, faith and belonging... Meaning in life comprises the engagement in or commitment to goals or a life framework and the subsequent sense of fulfilment and satisfaction or lack thereof.' (Brandstätter, Baumann, Borasio, & Fegg, 2012, p 1045).

However, the broad definition and individual perspective of MIL poses a problem for healthcare practice: How can a professional recognize when MIL is involved? MIL problems are considered as core issues in nursing (Schuurmans, Lambregts, & Grotendorst, 2012) and nurses acknowledge that MIL is important (Huber et al., 2013). The relevance of the topic is stressed by patient advocacy and healthcare bodies (Van Harten & Van Haastert, 2015; Wijgergang, Ras, & Reijmerink, 2016). In nursing methodology—the nursing process—professionals are encouraged to think critically and explore the situation of a patient in-depth and breadth, from a holistic perspective (Herdman & Kamitsuru, 2014; Wilkinson, 2011). One of the most applied classifications for nursing diagnoses, the North American Nursing Diagnosis Association (NANDA), provides many diagnoses related to MIL, for example in the mental and existential domain (Herdman & Kamitsuru, 2014). However, nursing literature regarding MIL of older adults is largely lacking (Hupkens, Machielse, Goumans, & Derkx, 2018). Several researchers mention that nurses do not recognize MIL of older adults in daily practice (Begemann & Cuijpers, 2015; van der Vaart, Arisse, Weijers, & Elteren, 2015). The first step to recognizing is perceiving when MIL is at stake in daily practice. Perceiving is a prerequisite to attentiveness (Klaver & Baart, 2016), which is a first step towards responsive 'good' care (Tronto, 1993). However, it is unclear what nurses could perceive in their daily practice regarding patients' MIL.

Although there are individual differences, we can identify seven dimensions of MIL (Derkx, 2011, 2015):

1. Purpose: What are a person's goals and strivings?
2. Moral values and justification: When and why does someone believe a goal is morally worthwhile, means are acceptable and what are the underlying values?
3. Efficacy: Does a person feel competent and able to influence something?
4. Self-worth: Does a person feel of worth for who they are and what they do? This may be influenced by being valued by others.
5. Comprehensibility: Do persons' life stories, including small events, make sense to them? Can they perceive coherence?
6. Connectedness: Does a person feel connected to other people, nature, something bigger and valuable?

What problem did the study address?

- Meaning in life is important for health, well-being, quality of life and what is considered 'a good life'. However, in daily practice, nurses have difficulties to perceive meaning in life.

What were the main findings?

- Older adults' meaning in life may come to light through the nurse–patient relationship and being in a private environment. Personal care and conversation are opportunities for revealing older adults' meaning in life.

Where and on whom will the research have an impact?

- This paper may help nurses in practice to recognize MIL in their daily work; Nurse education should learn nurses how to perceive patients' meaning in life; Healthcare managers and policy makers should consider the influence their decisions have on nurses' ability to perceive meaning in life.

7. Excitement or wonder: Does a person experience engagement in something worthwhile? Is there wonder and excitement in life?

In this article, we elucidate situations in everyday home nursing to diminish the mentioned knowledge gap and connect them to the theoretical framework of the dimensions of MIL.

2 | THE STUDY

2.1 | Aim

The aim of our study was to explore situations in daily home nursing related to MIL among older adults. The research question was: What are the situations in daily home nursing in which MIL of older adults, or the lack thereof, comes to light?

2.2 | Design

Qualitative research and, more specifically, observation, are appropriate for exploring behaviour in a natural setting as it takes place (Baarda, de Goede, & Teunissen, 2009; Kumar, 2014), such as daily nursing visits. As a preparation for this study, we interviewed nurses (not included in our sample) about MIL of older patients in their work, to explore the subject for a broader study. The interviews showed that nurses recognized the 'big questions' patients were struggling with but could not mention *daily* situations in which MIL or the lack thereof was involved. Through participant observations of home nursing visits, we wanted to elucidate those daily situations. Qualitative observations could provide us with the thick descriptions that were in line with our aim.

2.3 | Sample

Home nursing teams in the Netherlands consist of professionals with different educational levels, who cooperate to provide nursing at patients' homes. Teams were purposefully selected for our study. Purposeful selection is common in qualitative research to include participants who can help answering the research question (Baarda et al., 2009; Creswell, 2009). We selected teams in districts with different socioeconomic contexts, because socioeconomic status influences MIL (Pinquart, 2002). After having received information on the project, professionals of the teams were asked for their cooperation. We accompanied registered district nurses, assistant nurses and nursing aides (in this article, all 'nurses') during their daily rounds. The selection of nurses in the teams was a convenience sample. Most rounds were regular nursing rounds that consisted of many visits to patients at home.

2.4 | Data collection

The participant observations were conducted between September 2015–May 2018 by three researchers. Most participant observations were conducted during the day, but we also participated in a few evening rounds. Observations ranged from a few hours to a complete round. To enable an open attitude in the observation, no observation checklist was used (Baarda et al., 2009). Our participation during the observations was limited. For instance, observers joined slightly in conversations to avoid participants and patients feeling uncomfortable, or lent a helping hand turning patients in bed. Short handwritten field notes were made during the rounds and were transcribed to thick descriptions as soon as possible after the observations.

2.5 | Ethical considerations

We followed standard procedures for the Netherlands, including the Dutch Code of Conduct for Applied Research for Higher Professional Education (Andriessen, Onstenk, Delnooz, Smeijsters, & Peij, 2010). An ethics committee assessed the research proposal following Dutch guidelines. The research was found not to be subject to the Dutch Medical Research Involving Human Subjects Act. Nurses participated voluntarily. Patients received written information in advance about the project, which emphasized that they could refuse without any consequences. Participants and patients were invited to ask questions. Permission of patients was requested in advance by their nurses and repeated at the start of every home visit. Researchers behaved respectfully towards participants, patients, families, and their homes. Special attention was paid to anonymity in all notes and observation descriptions. In this article, we changed minor personal details and used pseudonyms and codes for the observations.

2.6 | Data analysis

The thick descriptions of observations were thematically analysed as described by Clarke and Braun (2015). Codes were initially grounded in the data (inductive coding). An additional, deductive phase was added to link the themes to the dimensions of MIL of Derkx (Table 1). Data were primarily analysed by the main researcher (SH). Dialogues took place in two interdisciplinary research groups in all phases of the coding process. Dialogue is regarded as a means to deepen and broaden understanding (Gadamer, 2004; Halling & Leifer, 1991), hence dialogue about preliminary findings guided latter observations and expanded interpretation of the data. This resulted in a cyclical process to understand the research topic.

2.7 | Rigour

To establish credibility, researchers were engaged in the field for a long time (>2.5 years) (Creswell, 2013). We also observed daily practice in diverse neighbourhoods with a variety of patients and home nurses with different educational levels. Rich descriptions provided details for transferability of findings (Creswell, 2009). Trustworthiness and reflexivity were fostered by several strategies: multiple researchers conducted the observations (Baarda et al., 2009); a reflective journal log (Baarda et al., 2009; Kumar, 2014); dialogue in research groups (Baarda et al., 2009; Creswell, 2013); and the use of analytical software (Atlas-ti 6.2.28).

3 | FINDINGS

In this section, we describe themes and subthemes (Table 1). Detailed examples are used to enable the reader's in-depth understanding. We refer to Derkx' MIL dimensions by numbers in brackets. Findings are based on analysis of 197 nursing visits to patients in eight Rotterdam-area districts. The examples show different neighbourhoods, nurses, patients, and observers.

There are many situations in daily home nursing where MIL of patients (or lack thereof) comes to light. This can be summarized in four main themes: being in a private environment; nurse–patient encounter embedded in relationship; personal care and conversation.

3.1 | Being in a private environment

Home nurses enter the houses of patients. We observed that being and perceiving in a private space provides insight into MIL of older adults. Subthemes for this theme are as follows: entering, signs and symbols.

Case: Mr Brown and Kate

> When we arrive at Mr Brown's house, Kate shows the bag of the care provider through the window. Then Mr Brown (age 86) can be sure she is a trusted person and opens the door. In the living room pictures have lost colour, plants are dehydrated. Newspapers lie on the table in a neat pile, unread. A large calendar-clock

TABLE 1 Codes, themes/subthemes, and dimensions of patients' meaning in life in daily home nursing

Inductive phase			Deductive phase
Themes	Subthemes	Codes	Dimensions of meaning in life[a]
1. Being in a private environment	Entering	Entering the house	2, 3, 4, 6
		Family and pets	1, 6
	Signs and symbols	Interior and artefacts	1, 2, 3, 4, 5, 6, 7
		Maintenance and housekeeping	2, 3, 4
2. Nurse–patient encounter embedded in relationship	Greeting	Hello and goodbye	1, 2, 3, 4, 5, 6, 7
	Seeing the patient	Mood, emotions, expression	1, 5, 6, 7
		Physical condition	3
		Self-care	2, 3
		Activities	1, 3, 4, 7
	Focus of attention	Intervention	3
		A whole-person in interaction with family/pets and environment	2, 4, 6, 7
	Interaction with nurse	Nearness-distance	2, 5, 6
		Familiarity and trust	2, 4, 5, 6, 7
		Reciprocity	2, 4, 6
		Rituals	2, 6, 7
		Time and pace	1, 3, 4, 6, 7
		Non-verbal communication	4, 6
3. Personal care	Adaptation to patientTouch	Choice and decision	1, 2, 3, 4
		Quality of touch	4, 6
4. Conversation	Communication skills	Language	3, 4, 6
		Communication ability	3, 4, 5, 6
		Speak, listen, ask, silence	1, 2, 3, 4, 5, 6
	Subjects	Care and health	3, 5
		Life story	2, 5, 6, 7
		Family, friends, neighbours	2, 5, 6, 7
		Actual problem	1, 2, 3, 4, 5, 6 ,7
		Activities and special events	1, 2, 3, 4, 5, 6, 7
		Plans	1, 2, 3, 4, 5, 6, 7
		Nurse and family	4, 6
		Healthcare organization	4, 5
		Society, news, politics	1, 2, 3, 4, 5, 6, 7

[a]1 = purpose, 2 = moral values and justification, 3 = efficacy, 4 = self-worth, 5 = comprehensibility, 6 = connectedness, 7 = excitement

stands on a visible place. When we enter, Mr Brown immediately walks to the kitchen, with brisk steps, without greeting us. (B-151209-OZ1-2)

3.1.1 | Mrs Livingstone and assistant nurse Zehra

While we are cycling to Mrs Livingstone's, Zehra tells me her patient is very ill and may die soon. She hopes that Mrs Livingstone's daughter, who lives in the same house, will be there, but when she opens the house with a key only a cat comes to greet us. Zehra silently climbs up the stairs. Maybe Mrs Livingstone is still sleeping. The house is untidy. It smells bad. Mrs Livingstone lies in the sleeping room in an adjustable bed. Above the bed hang a crucifix and a beautiful black-and-white picture of Mrs Livingstone when she was young. (C-170209-OZ1-3)

Entering. Like Mr Brown, many patients attached great importance to opening the door themselves (4). When patients were not able themselves, the nurse opened the door (3). Nurses frequently

paid attention to the fact that they were entering a private environment by ringing the bell, greeting, or taking off their shoes (2, 4). Sometimes significant others were there (even, in Mrs Livingstone's case, by being absent), sometimes a pet that needed attention. Pets are frequently of great importance, providing purpose in life for patients (1, 6).

Signs and symbols. Entering the house provided opportunities to observe and experience the private environment of patients. Are there photos of precious moments or relatives (5, 6, 7), fresh flowers (4, 6, 7)? Is the apartment well-kept (2, 3, 4)? Are there signs of what the patient was doing before the nurse entered (1, 2, 3, 7)? There may be spiritual artefacts (2). The house 'tells a story' about the person who lives there (2, 5). All observations can be the subject of a conversation with the patient.

3.2 | Nurse–patient encounter embedded in relationship

Relationships in home nursing are usually long-term and close-knit. This fact coloured the daily visits we observed (5, 6). MIL could be perceived in many aspects of the encounter between nurse and patient. Subthemes are as follows: greeting, seeing the patient, focus of attention, interaction with nurse.

Case: Mr Brown and Kate

Mr Brown has been waiting for us. He is wearing his pyjamas inside out, two different socks, his hair is dishevelled and he has a distressed look. Mr Brown tells, annoyed, that someone keeps hiding his teabags. Yesterday he found some under his pillow. Kate asks him if he wants to search together. When Mr Brown finds a teabag, Kate makes a cup of tea for him. She quietly mentions what she is doing: 'I am making a cup of tea with the teabag you just gave me'. (B-151209-OZ1-2)

3.2.1 | Mr and Mrs Graham and nurse Gregory

When we enter, a lot of family members appear to be around. Gregory takes off his shoes. Although Mr Graham is terminally ill and Mrs Graham wants to avoid unnecessary turmoil, she insists on drinking a cup of tea. Gregory quietly sits with Mrs Graham and listens to her story. She tells: 'He has been sleeping only for a few hours, but that's not enough. It is so terrible when you wake up at night and call out, but nobody responds. I know that from my own experience.' Gregory: 'Yes, of course he needs rest. I can see you are doing things perfectly.' He seems familiar with her. (E-151008-GV1-5)

Greeting. When nurse and patient meet they usually greet each other. The greeting sets the tone for the visit. In our observations greetings were cordial, sometimes with a kiss when there was a warm relationship, sometimes more formal (2, 4, 6, 7). Just like saying hello, saying goodbye was another important moment in the encounter. Appointments were made for the next visit or the nurse referred to an activity, e.g.: *"have a nice visit with your granddaughter!"* (1, 3, 5, 7).

Seeing the patient: The nurse sees the patient and vice versa. From the case of Mr Brown and Kate, we can learn that the appearance of the patient revealed information about him (1, 3, 5, 7). He was waiting for help (1, 3) but did not trust anyone (2, 6). From Kate's reaction we can understand that she perceived his confusion and attuned to his interpretation of the situation (5, 6).

Focus of attention: We observed that the nurse's focus of attention differed. In some encounters, the nurse was concentrated merely on the intervention that had to be performed, such as wound care or an injection (3). In other situations, the attention was focused on the whole person, family and environment (4, 6), like in the situation of Mrs and Mr Graham (1, 3, 6, 7). Attention to the patient as a whole human being may contribute to the experience of being a valuable person (4, 6).

Interaction with nurse: As the subthemes reveal (Table 1), we distinguished several characteristics. Some patients, like Mr Brown, were unsure as to whether they could trust personnel in their private space, sometimes due to cognitive decline. In this situation, the contact was distant, promoting self-respect and comprehensibility for Mr Brown (2, 5, 6). Other situations (see examples) reflected nearness, familiarity, and appreciation (2, 4, 6, 7). We frequently noticed reciprocity in the encounter (6). Despite their own sorrow, Mr Graham's family insisted on drinking a cup of tea, which reflected their value of hospitality (2). We observed nurses and patients who were accustomed to an appreciated ritual, like a specific greeting or a joke (2, 6, 7). Non-verbal communication, such as a glance or a hug, was important. It expressed connectedness probably more than conversation (4, 6). Interaction was further characterized by time and pace. Mostly the care had to be done in time, either because time is always constrained in home nursing or because the patient had an activity, for instance a visit to a doctor (1, 3, 6, 7). However, several nurses, as shown in the examples provided, chose to take their time and adapted to the pace of the patient (3, 4, 6).

3.3 | Personal care

Most times personal care was the central element in nurses' visits to patients. Subthemes for this theme are: adaptation to patient, touch.

Case: Mrs Livingstone and Zehra

When we approach her bed, Mrs Livingstone opens her eyes. She is over 90 years old. She looks fragile. Zehra says she has known Mrs Livingstone for a very long time already. 'Mrs Livingstone worked very hard all her life.' Mrs Livingstone smiles. She tells Zehra she

has a new grandson and she has seen him already: 'He is so little!' and her eyes radiate. Mrs. Livingstone says she would like to get out of bed for a little while. Zehra doubts: she doesn't know when Mrs Livingstone's daughter will return. It might take too long for Mrs Livingstone to stay up. Then Zehra asks her which clothes she wants to wear. Zehra shows her items that are comfortable both when seated and while lying in bed. Zehra helps Mrs Livingstone with a bed bath, getting dressed, combing her hair. She is very gentle with her. They don't speak much. Mrs Livingstone has many contractures. Zehra carefully turns Mrs Livingstone and helps her find a comfortable position in bed. All of Zehra's gestures express respect and tenderness. During our visit Zehra's son calls her: he is home again. Zehra tells that it is important for her to know that he is all right. Mrs Livingstone smiles and says: 'That's how mothers are. I know that!' (C-170209-OZ1-3)

Adaptation to patient. Many nurses, like Zehra, adapted the care according to the wishes and possibilities of the patient, while taking consequences into account (1, 2, 3). Nurses paid attention to the dignity and self-worth of patients by letting them decide, for instance, about clothing and the way to perform the care (4).

Touch. As Zehra showed us, touch is not solely instrumental. It is also an opportunity to express connection with the other as a valuable human being (4, 6).

3.4 | Conversation

Conversation usually started when the nurse entered the house: 'Hello! How are you today?' 'Did you sleep well tonight?' Sometimes it was the patient who started the conversation. Some patients talked from the moment we came in until we left (1, 6, 7), others preferred to share as little as possible (2). Subthemes for this theme are: communication skills, subjects.

Case: Mr Roberts and Beth

On our way to Mr Roberts Beth tells me that nurses assist him since he fell some time ago. Mr Roberts is an 83-year-old man diagnosed with cognitive disorder and depression. When we enter the house, Mr Roberts is already dressed. Beth motivates him to shave too. In the bathroom a conversation starts. Mr Roberts tells Beth he does not feel well, there is no pleasure in life anymore. He says he wants euthanasia. Beth takes the time to listen. She asks him what is troubling his mind. Mr Roberts tells her he had to give up his driver's licence. That robbed him of the freedom to go wherever he wanted. Since his wife died long ago, he managed to be independent. 'To lose my freedom is

the most terrible thing.' Beth listens and confirms that it is hard to accept. Then he tells about the burglary in his house recently... A neighbour chased them out. Mr Roberts continues talking, now about his granddaughter: she is going to be a mother. It will be his first great-grandchild! He says he is very excited about it. I can see his face brighten up. (D-170801-GV3-1)

Communication skills. Although most patients we visited were able to speak, we also met patients who had difficulties expressing themselves. In multicultural districts, nurses visited older patients who did not speak Dutch (3). Nurses had different cultural backgrounds and sometimes spoke with patients in their mother tongue (4, 6). Other patients had physical conditions that impeded speech (3). In all these situations non-verbal communication of nurses was crucial to show connection and respect (4, 6). Communication skills of nurses and patients play an important role. The nurses in our examples were skilled in listening, asking and using silence during conversation. This expresses not only respect (4) and connectedness (6), but can be related to other MIL dimensions as well.

Subjects. Conversation often started with common subjects like the weather or daily activities (1, 7). Often, the actual health status and care provided were subject of discussion (3, 5). As in other aspects of the interaction, the focus of the communication differed: sometimes it was directed at a technical intervention, sometimes at the patient (or his family), but more often it was reciprocal (5, 6, 7). We observed that in the casualness of personal care, small talk easily developed into a conversation about existential issues of the patient. The example of Mr Roberts illustrates this. Nurses and patients discussed many things and sometimes several in one visit, such as their activities for that day, plans for the weekend, their life story, children and grandchildren (1, 2, 3, 4, 5, 6, 7). Sometimes patients reflected with nurses on their past: Why did it happen that way? Did I do the right thing (2, 5, 6, 7)? Older patients were concerned or wondered about the future: What will be in it for me or for my grandchildren (2, 5, 6, 7)? Many patients spontaneously shared their concerns, for example about changes in the healthcare organization, politics, society, the position of older people, safety in the world, and the daily news (1, 2, 3, 4, 5, 6, 7). Nurses shared their worries about recently deteriorated working conditions (6). Frequently a nurse brought in a topic from the outside world that might interest a patient. Often, patients also asked nurses about their life, family and work (4, 6, 7).

4 | DISCUSSION

Our findings have implications for knowledge, practice, education, and public debate.

This article provides professionals with *knowledge* of situations in daily home nursing-related to older adults' MIL. As far as we know, this is the first empirical article about this subject. This paper adds a practical view to the current, mainly theoretical, literature about

MIL. Our results show that patients' MIL is highly perceivable in daily home nursing: in the private environment; in the nurse–patient encounter embedded in a relationship; in personal care; and in conversation. To summarize, MIL may come to light in every situation in (home) nursing.

Our paper may help nurses _in practice_ to recognize MIL in their work. However, understanding MIL goes beyond knowledge of themes or dimensions. Our exemplars show that MIL is embedded in nurse–patient relationship and the context of the situation. Nurses also need to learn _how_ to perceive MIL. This implies opening-up for what can be perceived. Martinsen (2006) explains how nurses can 'see with the heart's eye', which combines two ways of seeing: the first is _perceiving_ the other and feeling touched personally ('the other is a person like me'), the second is reflective and understanding ('the other is not me, I might be of help'). 'The heart's eye' lies in the interaction and the space, between perceiving and understanding.

As we can learn from Zehra and the other nurses in our study, 'seeing with the heart's eye' is the start of responsive 'good' nursing (Tronto, 1993). Therefore, nursing education should not only provide knowledge about MIL, but moreover, challenge students to 'see with the heart's eye'.

Finally, our findings show that organizational and societal circumstances influence nurses to perceive MIL during their visits. Several authors mentioned previously that nurses are unable to perceive what is really important for the patient as a person, because institutions and politics put pressure on nurses to narrowly focus on aspects that can be registered, like symptoms, minutes, observation scales, and interventions. This leads to alienation from the perspective of patients (Baart, 2011; Ranheim & Dahlberg, 2012). Martinsen (2006) describes this as 'the recording eye'. We therefore hope that this article will contribute to the _public debate about healthcare_. If MIL is important, healthcare managers and politicians should, besides nurses, be aware of the influence their decisions have on nurses' ability to perceive meaning in life.

4.1 | Limitations

Our study has limitations. Firstly, we observed single visits to patients, which are actually part of a longer nurse–patient relationship. This may have limited our understanding. Secondly, the nurses and patients may have behaved differently than usual during our observations (Hawthorne effect). However, observations did last several hours. We noticed that initially nurses were 'trying to do their best' but behaved more 'naturally' after a short time. Another limitation of the method (observations) is that findings do not explicitly reveal the voices of the observed persons. An avenue for future research may include the use of qualitative interviews, to elicit their perspective.

5 | CONCLUSION

The aim of this study was to explore situations in daily home nursing related to MIL of older adults at home. All of Derkx's MIL dimensions were recognizable in our observations. Using these dimensions allowed us to analyse situations in detail and, by doing so, bridge conceptual thinking about MIL to nursing practice. We conclude that MIL of older adults may come to light in every situation of daily home nursing. This implies that there are many opportunities for nurses to attune their work to patients' MIL. Empirical research is needed to further explore the nursing role about this subject. Nurses should be enabled at the educational, institutional and political level to develop perception and understanding—to have a 'heart's eye'.

CONFLICT OF INTEREST

The authors declare having no conflict of interest.

AUTHOR CONTRIBUTIONS

All made substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data; SH, AM, MG, and PD involved in drafting the manuscript or revising it critically for important intellectual content; All given final approval of the version to be published. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content; All agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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