Promoting the person-centred aspects of dignity and well-being: learning from older persons' experiences of living in residential care facilities

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Abstract

Purpose – *Dignity and well-being are key aspects of the legislation and policies that regulate care of older persons worldwide. In addition, care of older persons should be person-centred. Dignity and well-being are described as results of person-centred care (PCC). The purpose of this study was to gain an understanding of important aspects for older persons to experience dignity and well-being in residential care facilities (RCFs).*

Design/methodology/approach – *This study had a qualitative approach, and individual semi-structured interviews were conducted with 20 older persons living in RCFs. Data were analysed using inductive content analysis.*

Findings – *To experience dignity and well-being older persons emphasized the importance of preserving their identity. To do this, it was important to be able to manage daily life, to gain support and influence and to belong to a social context. However, the findings indicate a need for improvements.*

Practical implications – *Insights into older persons' experiences of important aspects for experiencing dignity and well-being in RCFs can be used by first-line managers and registered nurses when designing improvement strategies to promote PCC.*

Originality/value – *Dignity and well-being are described as results of PCC. The findings provide an understanding of what older persons perceive as important for experiencing dignity and well-being in RCFs. The findings are useful when designing improvement strategies to promote PCC.*

Keywords *Care, Dignity, Older persons, Person-centred care, Person-centred practice framework, Residential care facility, Well-being, Residential care*

Paper type *Research paper*

Introduction

Dignity is a key aspect in the care of older persons, aged 65 years or more (World Health Organization, 2016). Dignity is related to identity, and to preserve dignity, respect must be paid to a person's autonomy (Nordenfelt, 2003). Worldwide, people are living longer with both comorbidities and long-term disabilities (Abramsson *et al.*, 2017), which often leads to restricted autonomy (Nordenfelt, 2004). In addition to dignity, the international sustainable development goal number 3 indicates that well-being should be promoted for humans of all ages (United Nations, 2015). Well-being is described as consisting of physical, mental, social and environmental aspects of one's life (Kiefer, 2008). In addition to dignity and well-being, care of older persons should also be person-centred (World Health Organization, 2016), and dignity and well-being are key aspects of person-centred care (PCC) (Kogan *et al.*, 2016).

(Information about the authors can be found at the end of this article.)

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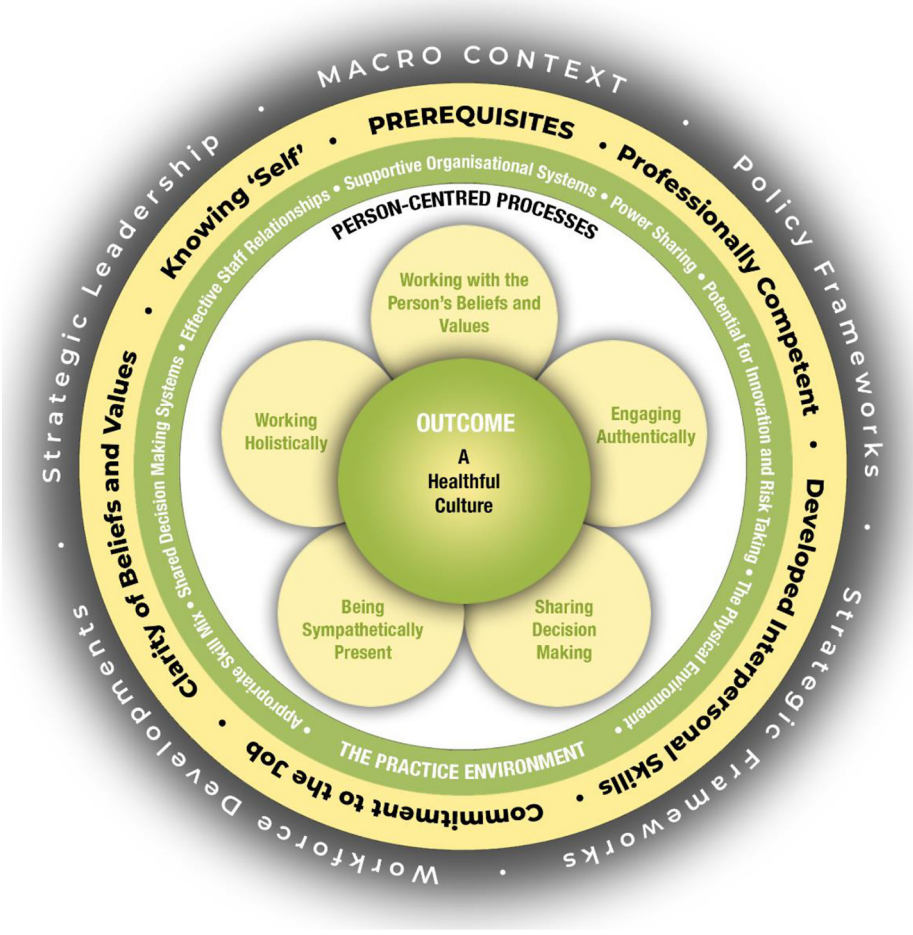
The person-centred practice (PCP) framework, see Figure 1, aims to put PCC into practice. The PCP framework describes dignity and well-being as results of PCC. The PCP framework contains the constructs of *prerequisites*, *care environment*, *person-centred processes* and *person-centred outcomes*. To achieve person-centred outcomes, the prerequisites of staff: knowledge, skills and attitudes to provide care, must be considered. When the prerequisites are applied in care, they are influenced by the care environment, for example, the physical environment where care is provided. The prerequisites and the care environment thereby influence PCC processes. PCC processes are characterized by providing care by having a clear picture of the person's beliefs and values. The prerequisites and the care environment have to be considered within to provide PCC processes to achieve the person-centred outcomes of dignity and well-being (Centre for Person-centred Practice Research, 2021; McCormack and McCance, 2006).

In Sweden, approximately 71,000 older persons (residents) are living in residential care facilities (RCFs). Most of them have an extensive need for care (The Swedish National Board of Health and Well-fare, 2018a). RCFs are staffed by registered nurses (RNs), responsible for nursing which includes promoting health and well-being. RCFs are also staffed by nurse assistants (NAs), responsible for assistance with personal hygiene,

Figure 1 Person-centred practice framework



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dressing, moving and cleaning (Ministry of Health and Social Affairs, 2001, 2017; The Swedish National Board of Health and Welfare, 2017a). First-line managers in RCFs are responsible for the staff and an important part of their work is to enable the staff to put the intentions of the legislation and policies into practice (The Swedish National Board of Health and Welfare, 2021). Most first-line managers in RCFs have a university degree in social work (The Swedish National Board of Health and Welfare, 2021).

Previous research indicates that dignity and well-being are not fully ensured in RCFs (Hasegawa and Ota, 2019; Paque *et al.*, 2018; The Swedish National Board of Health and Welfare, 2017b, 2018b, 2019; Tuominen *et al.*, 2016). Unless dignity and well-being are ensured, neither the intentions of the legislation nor policies that regulate care of older persons or PCC can be achieved. Therefore, from the experiences of residents, we need a more nuanced understanding of what aspects are needed to promote dignity and well-being. Residents' experiences can be used by first-line managers, RNs and NAs when designing improvement strategies to promote PCC. The purpose of the present study was to gain an understanding of important aspects for older persons to experience dignity and well-being in RCFs.

Methods

The study had a qualitative design (Polit and Beck, 2021) using individual interviews to collect data and content analysis to analyse data (Graneheim and Lundman, 2004).

Setting and participants

Data were collected in RCFs in Sweden. RCFs are financed by taxes, provide one-room apartments and the municipalities are responsible for the care provided there (Ministry of Health and Social Affairs, 2001). Eight men and 12 women were interviewed. The inclusion criteria were as follows: able to participate in an interview and to speak and understand Swedish and having resided in the RCF for more than one month at the time of the interview. Based on their personal knowledge of the residents, the first-line managers in the RCFs were asked to identify suitable informants, taking into account the inclusion criteria. Residents diagnosed with dementia were excluded; see Table 1 for an overview of the characteristics of the informants.

Table 1 Overview of the informants' characteristics

Characteristics	*Number of informants*
Gender	
Male	8
Female	12
Age	
65–79	1
80–94	18
95–	1
Duration of residence (months)	
0–12	6
13–24	4
25–36	6
37–48	1
48–	3 (72, 96 and 156 months)
Degree of assistance in everyday life	
Assistance with moving around	17
Assistance to wash or dress	14
Assistance to perform usual activities	13

Data collection

An interview guide with open-ended questions was used. Probing questions were used to achieve a deeper understanding; see Table 2 for the interview guide and probing questions. The interviews were performed by the first author, who has years of experience in nursing care for older persons and is experienced in interviewing. All informants chose to be interviewed in their apartments in the RCF. The interviews were conducted over a two-month period and lasted for 20–90 min each. Data were collected until data saturation was achieved. All interviews were digitally recorded and stored with a coded label.

Ethical considerations

The study was approved by a regional research ethics committee in Sweden and was carried out in accordance with the principles described in the Helsinki Declaration (The World Medical Association, 2018). Before the start of the interviews the informants received oral and written information about the study. Participation was voluntary, and informants were told that they could withdraw from the study at any time. Oral and written informed consent was provided before the start of the interviews, and the informants were guaranteed confidentiality. The informants had no prior relation of dependence with the interviewer.

Data analysis

Data were analysed inductively (Graneheim *et al*., 2017) using qualitative content analysis (Graneheim and Lundman, 2004). The interviews were first transcribed verbatim and verified against the digital recordings. The interviews were then read as a whole to gain a general understanding of the material. Thereafter, meaning units, which were words or sentences related to the study purpose, were identified. The meaning units were condensed while their core content was preserved, and the condensed meaning units were then labelled with codes indicating their content. The codes were then compared for differences and similarities, and based on this, they were grouped together into subcategories. Sub-categories with similar content were sorted into categories. The analysis process was dynamic and alternated between the parts and the whole. During the analysis process, one overarching theme emerged. The sub-categories, categories and theme that emerged were discussed several times by the research team, and the analysis proceeded until a consensus was reached. The members of the research team had years of experience in the research area and with conducting qualitative content analysis.

Table 2 Overview of the interview guide

Interview questions	*Follow-up questions*	*Probing questions*
Can you please tell me what is needed for you to experience dignity in your daily life?		Can you please tell me more about that?
Can you please tell me about a situation in your daily life where you experienced dignity?	What was important in that situation for experiencing dignity?	Can you please explain that more/ develop that?
Have your opportunities to experience dignity ever been put aside? If yes, can you please describe such a situation?	What would have been required in that situation for you to experience dignity?	Can you please give me an example of that?
Can you please tell me what is needed for you to experience well-being in your daily life?		Is there something more that is important for you?
Can you please tell me about a situation in your daily life where you experienced well-being?	What was important in that situation for experiencing well-being?	Please tell me what you think about that.
Have your opportunities to experience well-being ever been put aside? If yes, can you please describe such a situation?	What would have been required in that situation for you to experience well-being?	Please tell me how you experience that

Findings

The analysis resulted in one overarching theme: wanting to be treated like one still matters. This theme contained three categories: to be able to manage daily life, to be supported and to have influence, and to belong to a social context, each with further sub-categories. The theme, categories (henceforth written in bold italics) and sub-categories (henceforth written in italics) are presented in Table 3 and described in the text using quotations.

Wanting to be treated like one still matters

The overarching theme was described in terms of identity. Being seen as a person with abilities despite the need for care was emphasized as vital to experience dignity and well-being. Maintaining these abilities was described as important for having independence, and independence was described as important for preserving identity. Furthermore, maintaining their personal values and having their wishes respected were described as important for informants to preserve their identity. However, preserving their identity was challenging, as the informants had to balance the maintenance of their abilities and their personal values and wishes in relation to organizational routines.

To be able to manage daily life

The category describes the importance of maintaining physical and cognitive abilities and feeling free to experience dignity and well-being.

To maintain abilities by being physically and cognitively active was described as an important aspect of experiencing dignity and well-being. Regarding maintaining physical abilities, informants described that they intentionally performed daily workouts, such as climbing the stairs or taking a walk. Informants also described that they intentionally performed daily tasks such as washing the dishes. However, several informants described a fear of losing their physical abilities and that not being able to be independent would make life not worthwhile, as lack of well-being and dignity would ensue:

> Well, yes, otherwise [if you lose your physical abilities] you're done; you just lie in bed and can't get out. So, I make small tours around the place. That's to keep my legs in shape. [9]

As being cognitively capable was an important aspect for experiencing dignity and well-being, the informants described that they intentionally used their cognitive abilities to acquire new knowledge, for example, by listening to the radio, reading newspapers, solving crossword puzzles and playing cards. Major concerns were expressed about losing their cognitive abilities and how that would impact their sense of dignity and well-being:

> It would be horrible not to be capable and not to know what the date was and things like that, really awful, I think. I'm dreading the day that happens. [. . .] [In that circumstance] I don't think I could live a life that's worthwhile. [11]

Another important aspect was *to feel free*, and the informants emphasized the value of having an apartment of their own where they could manage on their own. In addition, it was

Table 3 Overview of subcategories, categories and theme that emerged from the data analysis

Subcategories	*Categories*	*Theme*
To maintain abilities by being physically and cognitively active	To be able to manage daily life	Wanting to be treated like one still matters
To feel free		
To feel encouraged by the staff to maintain one's abilities	To be supported and to have influence	
Want the staff to support influence		
To maintain and create new social relationships	To belong to a social context	
Want the surroundings to support social relationships		

important for informants to be able to easily get into and out of their apartments and the RCF by themselves. Nevertheless, several informants described a lack of freedom, as doors at the RCF were often locked, and this was described as feeling like being in a prison:

> I cannot go and come as I want to. I have to get help to get in because sometimes the doors do not work so the doors cannot be opened. Then, I have to wait until someone comes who can help me open the doors. You feel trapped. [2]

In situations where informants felt trapped, they experienced a lack of dignity and well-being.

To be supported and to have influence

The category describes the importance of feeling encouraged by the staff to maintain one's abilities and the desire that the staff should support informants having influence over their care.

An important aspect in this category was *to feel encouraged by the staff to maintain one's abilities*. Informants described it as important for staff to not assist too much, but nevertheless, there were stories of staff providing too much assistance despite the informants having the ability to manage by themselves. For instance, some informants were assisted with dressing even though they could dress themselves. Informants described how staff sometimes limited their abilities, for instance, their ability to take a walk outside, out of fear that the informants would injure themselves in some way, perhaps by falling. In situations where informants encountered this staff behaviour, they did not experience dignity and well-being. To feel encouraged by staff to maintain their own abilities, informants emphasized that staff should arrange different daily activities, such as baking, dancing, gymnastics and reading. Despite there being requests for such daily activities, there were stories of activities being arranged that were unstimulating or overly passive:

> Well, you know the way you sit around here, maybe passing a ball around with each other, I have a hard time accepting things like that, and maybe you understand. I don't know it's [laugh] it's a bit, well it's not my thing I guess. [4]

These situations were described as not supporting informants in maintaining their abilities.

To ensure dignity and well-being, there was a desire for *staff to support informants' influence.* An important aspect was being asked where, when and how the informants wanted their care to be provided. Informants emphasized the importance of staff being interested in their preferences and of these preferences being accepted even when they differed from those of the staff. When preferences were respected, the informants felt that their identity was preserved:

> Because if you are devalued, then you lose your value [. . .] if staff treat you like that. I would feel very inferior if I had received a different treatment. It is things like this that are very, very important. [5]

Nevertheless, several informants described having little say about their care. Some had experienced staff members making many decisions without asking about or taking into account the informants' requests and preferences:

> Well, I had visitors one day and it was long past eleven in the morning and my bed was unmade, so I told staff "I am so ashamed" when they don't make the bed. Because I have no problem telling staff what I think. I'm like that, I'm "straight" with people, tell them exactly what I think. But it is as if they don't care really. [20]

In situations where informants experienced the staff not supporting their influence over their own care, they did lack a sense of dignity and well-being. Informants described how in such situations, they experienced a feeling of having lost their identity.

To belong to a social context

The category describes the importance of maintaining social relationships with family and friends to experiencing dignity and well-being. Moreover, informants described the importance of their surroundings supporting opportunities for new social relationships with other residents in the RCF.

To maintain and create new social relationships was described as important aspects of experiencing dignity and well-being. Visits and/or phone calls from family members and friends were described as important, but nevertheless, several informants described missing friends who no longer came to visit them. The lack of visits was described as causing a situation where informants did not experience dignity and well-being. The informants further emphasized the importance of the company of other residents to their sense of dignity and well-being. Several found it pleasant to sit around the dinner table and talk to their neighbours at meals, and several described this as giving them a sense of being among family. Furthermore, having other older people to socialize with made the informants feel good:

> And sometimes I can be in a bad mood, it's natural, but then I go out and sit with the neighbours down here who have so much fun and laugh. Then, I'm happy. [12]

To experience dignity and well-being, the informants described that they *wanted the surroundings to support social relationships.* Although there were neighbours in the RCF with whom the informants could socialize, they nevertheless told stories about being lonely. Several described having difficulty talking to neighbours, owing to their reduced hearing acuity, which made it difficult to have a conversation around the dinner table. Another difficulty described was that many neighbours had dementia and could not follow a conversation:

> People with dementia are not much fun. It's the same thing over and over, exactly the same and you try to sit there and be polite and nice and say, you just sit there and agree, a person can't sit there indefinitely. It's really unpleasant to hear all that babbling or whatever you call it. It's not dignified either. No, I don't think it is. [11]

There were also descriptions of neighbours with dementia being aggressive and unfriendly, for example, when seated at the dinner table. Informants told stories of being told off by such neighbours, which made the informants wish they did not have to sit with them at the dinner table. To avoid such unpleasant situations, many of them instead had their meals alone in their apartments, which led to feelings of loneliness and a lack of social relationships. Informants described spending a great deal of time alone in their apartments owing to the disturbance caused by neighbours with dementia, and this was described as a situation in which informants did not experience dignity and well-being.

Discussion and conclusion

Dignity and well-being are key aspects of PCC, the legislation and policies that regulate care of older persons. The purpose of the present study was to gain an understanding of important aspects for older persons to experience dignity and well-being in RCFs. Being able to manage daily life, gaining support and influence and belonging to a social context were important aspects for older persons to experience dignity and well-being in RCFs. Nevertheless, our findings indicate that improvements are needed to promote dignity and well-being for residents.

Our findings indicate that informants intentionally strived to maintain their abilities, but that NAs sometimes did not support this, as they were afraid that the informants would injure themselves. Similar findings have been found in previous research (van Hell-Cromwijk *et al.*, 2021). According to the PCP framework, staff need to have the right *prerequisites*:

knowledge, skills and attitudes to promote dignity and well-being (Centre for Person-centred Practice Research, 2021; McCormack and McCance, 2006). With the support of the PCP framework, our findings suggest that NAs would benefit from opportunities to enhance their knowledge regarding residents' preferences of dignity and well-being. We suggest that conversations, from residents' point of view, are needed to increase this knowledge. This is also supported by the PCP framework, suggesting that conversational skills are important for showing concern for people's situations and finding mutually agreed upon solutions (Centre for Person-centred Practice Research, 2021; McCormack and McCance, 2006). According to the PCP framework, NAs should be given the opportunity to also develop their skills regarding conversations, as improved conversation skills seem to be crucial for better considering residents' own preferences regarding their dignity and well-being. As RNs are responsible for supporting staff to ensure dignity and well-being (International council of nurses, 2012), we believe that RNs can play an important role in supporting improvement strategies in terms of NAs knowledge and skills in this area. In addition, first-line managers need to provide NAs with appropriate conditions, in terms of time, to engage in such improvement strategies.

According to the PCP framework, the physical environment is part of the *care environment*. The physical environment includes both choice/control and safety (Centre for Person-centred Practice Research, 2021; McCormack and McCance, 2006). Because NAs sometimes did not support informants in using their abilities, as they were afraid that the informants would injure themselves, a possible interpretation could be that the NAs concerns about safety in the physical environment were considered at the expense of informants having choices and control. Residents and NAs seem to have different preferences when it comes to safety, which has also been found in previous research (Dahlke *et al*., 2019; Lette *et al*., 2020; Saarnio *et al*., 2019). The NAs preferences might be considered in light of how they interpret the legislation regarding safety (Ministry of Health and Social A ffairs, 2010), but it is important that they are aware that their interpretation of such legislation might cost residents their sense of dignity and well-being. If NAs believe that residents will injure themselves when exercising their ability to be independent, this implies a barrier for residents to experience dignity and well-being. In this respect, first-line managers and RNs play a key role in guiding staff to interpret the legislation. This guidance is important for NAs to feel comfortable promoting residents' sense of dignity and well-being.

With regard to improvement strategies it should be noted that first-line managers in RCFs are responsible for enabling NAs to put the intentions of the legislation and policies into practice. Most first-line managers have knowledge and skills related to social work (The Swedish National Board of Health and Welfare, 2021). RNs are responsible for nursing and have knowledge and skills related to health and well-being (Swenurse, 2017). Our findings indicate a need for first-line managers and RNs in RCFs to integrate their different knowledge and skills and to work together as a team when they develop improvement strategies to promote dignity and well-being. The participation of different professionals working together has also in previous research been described as essential for implementing PCC (Ebrahimi *et al*., 2021).

Our findings, which describe residents' experiences, can be used by first-line managers and RNs when they develop improvement strategies to promote dignity and well-being, namely, PCC, for residents. In addition, as both the attitudes of staff and the care environment were described as important aspects for experiencing dignity and well-being, we suggest that the PCP framework, targeting these aspects, could be used as a theoretical framework when developing improvement strategies to promote dignity and well-being.

Study strengths and limitations

As first-line managers were asked to identify suitable informants based on their personal knowledge of residents, there is a possibility that the sample included informants with a more positive attitude towards the RCF. If that is the case, the selection of informants may

have resulted in biased findings that falsely portrayed favourable situations, which might be considered a limitation. The risk of this seems to be small, however, as the findings include descriptions of both positive and negative experiences regarding dignity and well-being. It can also be considered a limitation that the sample was not diverse in terms of ethnicity. In addition, it should be noted that the study was carried out in the context of publicly financed Swedish RCFs, and the organization of RCFs might differ in other countries. However, the findings might be transferable to older persons in similar situations. In the study all the authors participated in the data analysis, which alternated between the parts and the whole and was discussed until a consensus regarding the interpretation was achieved, which might be considered a strength. However, it should be noted that other interpretations are possible.

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