

A sense of home in residential care

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Scand J Caring Sci; 2012; 27; 999–1009

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Moving into a residential care facility requires a great deal of adjustment to an environment and lifestyle entirely different from that of one's previous life. Attachment to place is believed to help create a sense of home and maintain self-identity, supporting successful adjustment to contingencies of ageing. The purpose of this study was to deepen our understanding of processes and strategies by which older people create a sense of home in residential care. Our findings show that a sense of home in residential care involves strategies related to three dimensions of the environment – attachment to place, to space and attachment beyond the institution –

and that the circumstances under which older people manage or fail in creating attachment, consist of psychosocial processes involving both individual and shared attitudes and beliefs. Assuming that attachment is important to human existence regardless of age, attention must be paid to optimize the circumstances under which attachment is created in residential care, and how nursing interventions can help speed up this process due to the frail and vulnerable state of most older residents.

Keywords: place-attachment, home, institutional care, ageing, elderly.

Submitted 19 September 2012, Accepted 24 September 2012

Introduction

The overall aim of the Swedish ageing-in-place policy, originally declared by the Swedish government in 1990, is that older persons should have the opportunity to remain in their own homes with support from home help services, home health and outpatient care for as long as possible. Transferring care from formal spaces, such as hospitals and institutions, to informal settings, such as the home, permits the great majority of older persons in Sweden to accomplish the process of ageing outside residential care facilities (1,2). However, when the caring needs of the older person no longer can be met in the home, moving into a facility that provides round-the-clock supervisors usually becomes a necessity. Dementia and cognitive decline are strong predictors for institutionalization (3), and about 14% of persons ≥ 80 years, of which the majority are female, reside permanently in different forms of special care for the elderly in Sweden (1,2). Both conventional wisdom and research evidence suggest that

older persons move to residential care primarily because they must, that is, secondary to senescence, disease and trauma (4), and that such a move requires a great deal of adaptation and adjustment to a new environment and lifestyle that is entirely different from that of one's previous life (5). The move has been described as stressful and challenging, usually precipitated by some kind of loss, either in terms of one's home, independence, spouse or significant other (6). Based on previous evidence, stating that there is a strong relationship between the place we call home and our self-identity, it might be suggested that the social subject invested with meaning by others is intimately bound to where we live (7–9). Numerous authors have noted that the place we call home becomes increasingly important as we age (10,11). As humans, we usually take great pride in where we dwell, meaning that the appearances and locality of the body influence social life and mobilize social identity, thus making ageing both an embodied and emplaced process (12,13).

Background

In proportion of gross domestic product (GDP), Sweden offers more publically funded elderly care than any other country in the world (14). The elderly care in Sweden is based on national clinical practice guidelines and is primarily public sector tasks. The Social Services Act

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(2001:453) is a framework law that emphasizes the right of the elderly person to receive satisfactory municipal services based on his/her individual needs and wishes. The Health and Medical Services Act (1982:763) emphasizes his/her right to high-quality health care regardless of geographical location. The ideal residential care facility has been described as a place that upholds human values, where persons live their lives with as little discomfort as possible, with dignity and high quality of life in ways as similar as possible to their previous life in their private homes (15,16). Central in this description is the maintenance and perseverance of independence, autonomy and privacy. However, research has also described the residential care facility as a place endowed with suspicious awareness and mutual pretense, where overloaded nursing staff shows little engagement with the residents (17), and waiting for assistance undermines the residents' sense of self and dignity as well as quality of life (18–20). The semi-public nature of the residential care facility makes it incomparable in that we wish our residents to call home a place that is a primary site of care provided by professionals. This dialectic movement between the formal rules and norms posed by the institution, and the informal social norms of the home, makes it a complex and unique site of care (21–23), and this inherent ambiguity signifies the very nature of the residential care environment, making it interesting also from a research point of view (24). Moving beyond the meta-concept of nursing environment (25–28), the central tenet of health geography is that the environment changes as the older person takes from it what he or she needs, controls what can be modified and adapts to conditions that cannot be changed (29,30). Central to these person–environment transactions is the concept of place-attachment, which involves emotions, cognition, knowledge, beliefs, behaviours and actions (31). Focusing our attention to the process by which the home place can be constructed, the ability to feel at home relies heavily on one's emotional attachment to that geographic location, binding a person to that place as a function of its role as a setting experience (10,11,32).

As such, the physical and psychosocial environment contains both spaces and places that are more than passive containers of social life (12,13,33). Place can be conceptualized as a complex, symbolic and cultural construction (4) that possesses meaning through human agency, intentionality, essence, authenticity and embedded knowledge (31). Its spatial dimensions employ both the private and the public sphere (29), including its symbolic objects that have profound impact on people's sense of self, of who they are and feel that they are able to be (34). Space, on the other hand, can be conceptualized as an objectively identifiable context, or the web of social relations that fills the place, both real and imaginative, as well as symbolic (9,12,22,34). The home place represents

'the quintessence of private space' (35,36) and is embodied with physical, emotional, social and symbolic significance, created through interaction over time, routines and rituals, meaning that it integrates physical, psychosocial, as well as temporal aspects of place-attachment (23,36). The atmosphere has been described as the 'personality' of a setting and is supposed to mark its quality or character. The atmosphere can be understood by two interacting dimensions: the physical environment, and people's doing and way of being in the environment (37,38), subsequently intersecting attachment, place and space, as well as the private and the public.

This explorative study was guided by the concepts of space and place (4,38,39), as it was proposed that these concepts may further expand our understanding about the nursing environment and the processes involved in the creation of attachment and a sense of privacy, because life in residential care characteristically involves loss of privacy, limited boundaries, fixed schedules and loss of control (40,41). Despite a long-standing history of geographical research, especially in studies about persons living in different kinds of institutions (33,42), the reconciliation of the dual nature of the residential care facility in terms of private and public has not yet been fully explored. The aim of this study was to gain a deeper understanding of the processes involved, and the strategies by which older persons create a sense of home, place-attachment and privacy in residential care facilities.

Method

Design

Constructivist grounded theory method explicitly assumes that neither data nor theories are discovered and that we construct our grounded theories through our past and present interactions with people, perspectives and practices (43,44). In this study, we used a constructivist grounded theory method due to its purpose to generate theory that provides an understanding of the complexity of the world, its views and actions, positioned in specific situations, spaces and times (43–45). Building on its pragmatist underpinnings, constructivist grounded theory explores meaning, process and action by getting as close to the experience as possible (46). Although the developed theory is a constructed interpretation of reality in relation to specific contexts, the logic of the method facilitates transferability of findings to the realm of formal theory (45). Action is its central unit of analysis (47), and by taking an 'agentic' position, viewing actions and meanings as emanating out of interaction rather than from within the individual herself, constructivist grounded theory subsequently focus on process rather than structure and discovery (43,44,48,49). Process and development imply that something happens over time.

The simultaneous theoretical sampling and interpretation of data (45) develop and refine the portrayal of experiences through the construction of theories.

Sample and settings

The sample and setting originate initially from a previous study (50) of older persons' experiences and understandings of an inter-institutional relocation (i.e. an involuntary move between institutions due to various reasons). In that study, six respondents were interviewed on several occasions over time. While analysing these interviews, it became apparent that their narratives of the relocation also included rich descriptions of institutional life and ageing in general, both in terms of one's deteriorating body as well as the residential care facility as a place of confinement and solitude. This opened a plethora of research questions about how older persons manage their daily life in residential care, as well as the strategies and processes that might be involved in the processes of transforming institutions to homes. The sampling procedure that followed was both purposive and convenient. Consistent with the emergent character of the grounded theory method used in this study (44,45), the sampling evolved as data were interpreted.

Four residential care facilities in the central parts of a large city in Sweden were approached for participation in this study. Residents were initially introduced to the study by their nurse practitioner (NP). Inclusion criteria were set at being able to participate in an interview, speak and understand Swedish and that the respondent had resided at the facility for more than 6 months at time of interview. 19 older persons gave their permission to be approached by the first author (HF) with more information about the study, of which all gave their informed consent to take part in the study. Thus, altogether the analysis is based on repeated interviews with 25 respondents (21 women and four men), six from the prior study and 19 from the present study, mean age 82 year for both men and women. The mean length of stay at the residential facility at time of interview was for both sexes 9 months.

Ethical considerations

The first author (HF) conducted the consent process, explained the study to the respondents and read through the consent letter prior to obtaining signatures. One of the challenges in conducting research that involves the old and frail is the ethical issues surrounding their dependence towards those working at the residential care facility and vulnerability. At time of each interview, the first author (HF) offered the respondents to choose a location where they felt they could speak freely, that all interviews were confidential and that no one in the

research team was affiliated with either the residential care facility or any of its employees. If interviews aroused strong feelings, follow-up interviews could provide comfort by letting the respondents talk about what they thought was important or frustrating, regardless of whether it had anything to do with the research question. The study was approved by the Regional Ethics Committee, Gothenburg University (PRO ID # 572-06).

Data collection

Trustworthiness of data and the process of analysis are partly judged on the explanatory value and the conceptual density and scope of one's findings. Considering that data are constructed through processes of interaction and communication (45), attention must be paid to the quality of the interview in terms of thick and rich descriptions (49,51) and that data are influenced by both reflexivity and relationality (45,46,48).

In this study, data were gathered using face-to-face interviews to explore older persons' experiences and understandings of life in residential care, as well as the actions, strategies and processes involved in the creation of a home in an institution, and redefining self-identity in the presence of frailty and independence. The interviews were conducted by the first author (HF). The opening question to each interview was: Tell me what it is like to live in residential care? Based on the reply to this question, follow-up questions were asked, for example: How did you do to settle in at the residential care facility, or tell me about your thoughts and feelings when you moved from your old home into residential care? All interviews took place in the respondents' private rooms at the residential care facility and lasted on between 20 and 80 minutes. The length of the interviews was related to the level of frailty of the informant, and in three cases, interviews were interrupted due to the informants fatigue and inability to proceed. Interviews were digitally tape recorded and transcribed verbatim by the first author (HF) to minimize the difference between the oral and written discourse (51). Consistent with the emergent character of the grounded theory method used in this study (45), the analysis evolved as data were collected and interpreted.

Analysis

Comparison of differences and similarities between segments of data, codes and categories was made continuously throughout the analysis. Consistent with the emergent character of grounded theory method (45–47), the analysis evolved as data were collected and interpreted. Transcribed interviews were read to obtain a holistic view and understanding of the respondents' situation. Segments of data that included experiences,

thoughts, feelings and actions related to life in residential care were selected and sorted into initial codes and labelled using a language that adhered closely to the data. Codes were sorted into tentative categories, which were abstractly labelled and described according to their meaning denoting action. Initial codes and categories were constructed without any specific theoretical direction. Comparison between the properties and parameters of the categories distilled and streamlined the analysis, which resulted in more abstract and robust categories. Selective coding is about finding what drives the conceptual model forward. By using additional information acquired through focused interviews, and applying the spatial framework of place and space, categories were refined, developed and saturated. Theoretical saturation was reached when new data no longer revealed new properties to the categories (44–46). In this process, three concepts emerged (see Findings section), to which all categories were related. Also, the processes influencing the creation of attachment could be divided into either being supportive or hindering. Figure 1 illustrates how strategies and processes are related. All respondents were given pseudonyms when quoted.

Findings

Our findings show that the construction of attachment and creation of a home in residential care involve strategies that can be related to three dimensions of the environment: attachment to place, attachment to space and attachment beyond the institution. Our findings also show that the circumstances and conditions under which older persons either manage or fail to create attachment consist of psychosocial processes involving both individually and collectively held attitudes, beliefs and symbolic meanings.

Strategies creating attachment to place

Actions used by the respondent to create a home were for the purpose of this study regarded as strategies, and those that created attachment to place consisted of two dimensions: nesting and being in charge. Personalizing the environment, making room for personal belongings with furniture and memorabilia transformed the private room to a place of recognition and familiarity that symbolized and strengthened one's self-identity, distilled from a lifetime of memories, experiences and meanings attached to them. However, by reconciling the inherent ambiguity of the institutional place, and to furnish the room in ways that compensated for loss of function and enabled the use of walking aids, respondents successfully incorporated their frailty into the environment. For example, Lilly said:

I brought the things I wanted when I sold my old home, and told my boys how to arrange them once we got here. You see, I need the walker to get around, and that requires a lot of open floor space. As you can see, this room is adapted to suit my difficulties, so to speak.

Central to nesting and the creation of attachment to place was spending time in one's room or apartment. Within the private sphere, respondents engaged in domestic chores, such as dusting bookshelves, polishing old photographs, ornaments and silverware, and doing some light housework. Preparing oatmeal in the morning or an evening snack constructed attachment to place. Being able to independently set the agenda for the day and trying to live in the same manner as one always had, for example, solving crosswords, a piece of knitting, listening to the radio, looking at photographs, reading the newspaper, play solitaire or watch TV, were

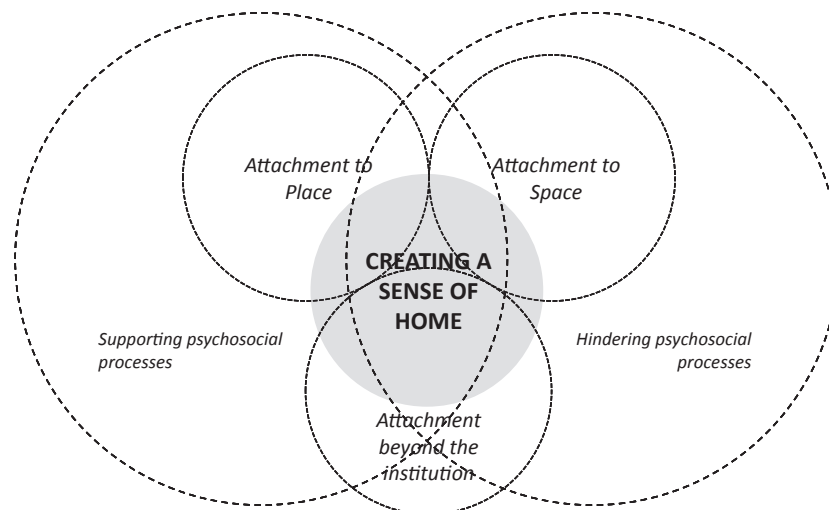


Figure 1 Creating a home in residential care.

experienced as moments of privacy imperative for feelings of being at home. Co-residents were perceived, in most parts, as strangers that intruded this privacy unless invited. A central aspect in creating attachment to place was that of being in charge, and to independently decide whom to include and to exclude.

To invite a co-resident to one's private room was equivalent to that of inviting someone into one's home. For example, Rose said:

I'm acquainted with almost everyone here, but there's one in particular and she lives on the other side of the hallway from me. We're really good friends and we usually invite each other over a glass of wine in the evenings. Besides that, I've made a system of not letting anyone in my room. I don't want unfamiliar people running around in here, and I want to feel that this is mine and that I can do whatever I want in here.

Although the nursing staff had keys, the locked door symbolized privacy. The staff was welcome when the respondents needed assistance. However, when they were away from their room, the locked door symbolized that no one was welcome to enter. A breach of that rule was experienced as infringement; however, when respondents felt sick, tired, weak or in need of more assistance than usual, the nursing staff's ability to enter their private room single-handedly contributed to a sense of safety. For example, Ruth said:

When I was down with the tummy flu, there were many unfamiliar people in here that helped me and that didn't bother me at all. To me, the unfamiliar ones are those living down the hallway. The nursing personnel are more than welcome to enter if I need help.

Strategies creating attachment to space

Strategies constructing attachment to space consisted of three dimensions: taking part in activities with others, expressing personality and making friends. Imperative for the creation of attachment to space was the ability to independently decide when and how to interact with co-residents and nursing staff. Weekly activities at the residential care facility, such as physical exercise, music entertainment, bingo and church services, offered an opportunity to seek contact with other residents from different units at the care facility.

The spatial layout in shared spaces with lounge furniture and dining tables invited to a cup of coffee and some small talk with nursing staff and co-residents that contributed to a sense of community and belonging, which was reported as a good way of spending time. Socializing with others made respondents aware of their physical appearance, and the opportunity to dress up and to have one's hair set was important to maintain continuity of

sense of self-identity and personal values. For example, Chloe said:

Oh, I just love when they (nursing staff) wake me up in the morning and I know that today is the day we're going for a trip to Denmark, or have a day in the country. I get a chance to dress up nicely, to put some make up on, and to make myself look decent. Those are the best days here... when you have a reason to get out of these old and ragged clothes.

Another way of expressing independence, dignity and sense of self-worth was to set boundaries towards the nursing staff, and such relationships based on mutual respect contributed to an atmosphere of tolerance that made respondents speak more freely about their preferences. Also, the nursing staff seemed to adhere to a higher extent to the likings of the respondents, which was important in the construction of attachment to space.

Respondents perceived themselves as equal to, and respected by, the nursing staff, by sharing an understanding of the residential care facility as being someone's home, which preserved the continuity of the respondent's normal lifestyle, and strengthen their sense of self-worth and dignity. Making friends was an important aspect of attachment to space. Social relationships included acquaintance with nursing staff, as well as friendship with co-residents that one confined in and trusted. Seeing that the private room was home, respondents visited each other over a glass of wine or a cup of coffee. Sharing autobiographical memories and old photographs, to talk about day-to-day events and in-home were important to maintain a sense of continuity of self-connecting with the past, as well as to become acquainted and get to know each other. For example, Phyllis said:

I didn't think you could meet new friends at my age. When you we're younger you became friends with everyone... and now... well, you can say that life has made me picky. Anyway, to me it seems like I've known Agnes all my life and she lives down the hall from me. There's just one small problem... she doesn't hear so well and that makes it impossible to whisper any secrets.

Strategies creating attachment beyond the institution

These strategies consisted of two dimensions: bridging the gap between past and present, and home is someplace else. Having frequent visits, talking on the phone, writing letters and to go places for holidays and weekends bridged the gap between the respondents' present frailty and their past lifestyle. By having the nursing staff helping and supporting only when their strengths failed, respondents used the residential care as means to pursue their self-determined goals and to keep up appearances.

Being active in everyday life despite impairments was reported as important. Some respondents engaged in activities arranged by the community, such as meetings for seniors, recognized membership organization and bimonthly meetings with the local government, which help them to preserve their continuity with the past and society, as well as to reach beyond the institution. For example, Frank said:

Oh no, I'm not sorry one bit that I'm in a wheelchair and can't cope on my own. I'm still the captain of this ship, and I do whatever I want... I just need a little bit of support.

By constructing attachment beyond the institution, some respondents viewed the residential care facility as a place where they slept and ate, but did not live. The notions that home where someplace else was related to the view that one's housing at the residential care facility was only temporary, making settling in unnecessary and uncalled for. Respondent's old home, either kept for various reasons or sold, would always be the place to call home, and despite the fact that housing at the residential care facility was permanent, returning home was regarded as a possible alternative if things did not work the way one wanted. Actively refraining from personalizing the private room strengthened the notion that home was someplace else. Despite its seemingly illogical nature, attachment constructed beyond the institution provided the respondents with a sense of both control and belonging. For example, Bertha said:

I just brought the essentials... my furniture is still at home and I've been here for 6 months now. My daughter is taking care of my apartment while I'm here. It feels good to know that I'll always have my own place if I decide to move back.

Psychosocial processes supporting attachment

The circumstances and conditions under which the respondents managed to construct attachment and create a home were for the purpose of this study regarded as supporting psychosocial processes. These processes comprised four dimensions: accepting frailty, looking on the bright side of life, reconciling oneself with one's biography and feeling valued. Respondents viewed the course of ageing, and its subsequent feebleness, as a natural and anticipated part of life. Accepting frailty was related to an understanding that the residential care facility symbolized loss and infirmity as well as being a place of protection and care. Accepting frailty was described as reaching the terminus of life, to understand the reasons to, as well as to independently choose to, move into residential care. Experiencing symmetric power relations to the nursing staff was an important dimension of feeling valued, and was experienced as reliant and well inclined, which contributed to

sense of self-worth. Another fundamental aspect of processes contributing to attachment was the ability find pride in managing even the smallest chores by your own. The talent to downplay the negative aspects of institutional living, to decide to make the best of things and looking on the bright side of life could partly be associated with having no other option than to live in the residential care facility but to accept the situation and making the best out of it. However, it was also described in relation to an understanding that creation of attachment requires effort and that such a creation needs support. For example, Violet said:

I sat down and reasoned with myself and decided that I wanted to move here and that would feel at home, that the food would taste great and that all the people here were kind-hearted. If I didn't set my mind to it, it would be impossible for me to live like this... so that is what I did and that have worked out just fine. Does that sound crazy to you?

Respondents often felt grateful towards those who took care for them. Both nursing staff involved in the day-to-day care and those in charge of the facility were regarded as doing their best with limited resources. By reconciling with one's biography, the respondents described a calm and assertive acceptance of the inevitable end. Awaiting death was regarded as the final natural step of life, and whenever one's time was up, death was welcome to pay a visit. For example, Hilda said:

It's just a part of life, I guess. We'll all end up like this if you live long enough graced with a long life. Having that said... for my own part I really hope that when it starts going downhill it will be fast. The worst thing that could happen is if I end up like one of those in need of incontinence pads and feeding tubes. I hope that I'll manage independently all the way to the end. That's really my only wish for the future.

Psychosocial processes hindering attachment

The circumstances and conditions under which the respondents were unable to construct attachment and create a home were for the purpose of this study regarded as hindering processes, which comprised four dimensions: rejecting frailty, being a burden to oneself and others, giving up and feeling discarded. The unwillingness to accept growing old and to become frail resulted in a state of emotional limbo, leaving the respondents well aware of their need for assistance, but at the same time in mourning over losses in terms of capability and independence ascribed to their old self-identity.

The feeling of regarding oneself as out of place, without the same impairments and needs as the other residents, was related to a sense of unwillingness to conform

to the residential life. Much that once was, was lost. The sadness of losing sense of self-identity and youthful looks made respondents ashamed over their corporeal decay, which in turn contributed to isolation and strengthened their feelings of being an outsider. Negative self-conceptions about being a burden to others, rather than contributing, diminished the respondents' self-esteem and self-confidence. The discrepancy between their desire to independently cope with everyday life and the limited ability to do so contributed to feelings of bodily imprisonment, which had little to do with the spatial dimensions of the residential care facility *per se*. With low self-esteem and self-confidence, the respondents felt insecure and afraid that their remaining abilities would fail them if they tried to cope independently, which strengthened the feeling of imprisonment and isolation. For example, Wanda said:

The fact that I don't have the strength to do anything besides to sit in that chair and watch TV... Everything is difficult when you're in a wheelchair. Before I got this heart condition, I was independent and could do whatever I wanted whenever I wanted... Now these four walls have become my universe.

When evaluating life in residential care, respondents judged their needs and expectations as unmet, which in turn gave rise to disappointment, frustration and dissatisfaction. Quite common sense, none of the respondents had expected to be in need of residential care at the end of their lives. However, when the need for residential care became apparent, respondents expressed that their expectations become a part of a larger and stable structure that provided a sense of belonging were unaccounted. For example, Daisy said:

When I signed up for this place I thought that I'd meet like-minded people and that we all could have a nice time together the last days or years of our lives. I hoped that it at least was someone here that I could make friends with, go for walks with, and talk about books with and... but there isn't.

Besides social expectations, other unmet assumptions about life in residential care could also result in feelings of disappointment, frustration and dissatisfaction. Respondents described that they prior to moving into residential care thought that it would imply a higher degree of being looked after, that it would mean that one would have access to physiotherapists and rehabilitative training and that the proximity to physicians and Registered Nurses would guarantee optimal care. Statements describing ageing and frailty, as a change for the worse into a less desirable or inferior state, or going from bad to worse, left the respondents in a lack of hope. For example, Adhelm said:

What can I possibly wish for? What can anyone look forward to in my situation? I'm well aware that I'll only become worse, and one day I won't be able to

walk at all. At first when I moved in, I could manage on my own and now I'm unable to even stand straight without my walker.

The dignity of the respondents was violated when nursing staff made them wait for help, ignored their wishes, intruded their private sphere, subsequently making respondents feel insignificant, without value and without the ability to change their position. The language sometimes used by the staff connoted their powerlessness that was related to feeling dismissed. For example, John said:

Nothing good comes with old age. Nobody takes you seriously anymore. It's not like they're saying it straight to your face, but I can see that they're thinking that I'm old and that everyone at the age of 92 are senile.

Respondents lacking trust in nursing staff felt reluctant to speak freely when they thought something was wrong. Although most respondents regarded the nursing staff's infringed behaviour as merely caused by carelessness, a fear of reprisals made the respondents insecure about their own value and capability, subsequently undermining their sense of self-worth and dignity. The inability to recognize legitimate reasons for moving into residential care was related to feelings of being dismissed, disempowered and devaluated. For example, Judith said:

They called my daughter and said that I needed to make up my mind about moving to this place by following Monday at the very latest. This was a Friday afternoon, and I felt unsure... but then I decided to say no, I didn't want to leave my home. My daughter called early that Saturday morning saying that she and her husband were on their way and that I needed to get ready. I didn't understand a word she was saying, and asked what they in God's name were up to? We're moving your furniture today and everything is arranged at the residential care facility for you to move in by Monday, my daughter said. That night my heart was pounding and I couldn't stop crying. My daughter and her husband are decent people, and I know that they only meant well, I just wish they'd asked me what I wanted.

Discussion

A good quality of life in residential care is achieved when we are able to adopt strategies that allow residents to attach to the social and material fabric of everyday life (34). The purpose of this study was to gain a deeper understanding of the processes and strategies by which older persons that can no longer be cared for in their ordinary homes create attachment and self-identity in residential care facilities. Our findings show that the construction of attachment and creation of a home in

residential care involve strategies related to three dimensions of the environment: attachment to place, attachment to space and attachment beyond the institution. Our findings also show that the circumstances and conditions under which older persons either manage or fail to create attachment consist of psychosocial processes involving both individual and shared attitudes, beliefs and meanings.

The spatial dimensions of the residential care facility employ both the private and the public discourse (29). It cross-sections place in terms of the shared areas and private rooms, and space in terms of social relationships being either intimate, acquainted or professional. By adding a 'private vs. public' perspective on top of place and space, the diversity and complexity of the semi-public environment were captured. According to our findings, the act of inviting someone into one's private sphere was the practical application of one's ability to independently include and exclude. Inviting others could either stem from a need for assistance by the nursing staff or a desire to socially interact with a friend. According to an article on home-based nursing care (52), patients perceived themselves as guards, protecting their independence and home space from others. There are obvious ways in which the situation determines our activities and thoughts (9). Within the private sphere, those invited usually take on a friendly and personal attitude to maintain a good relationship. According to our findings, nursing staff was regarded as welcome when assistance was needed. Nursing staff entering the private rooms of residents without an articulated and clear purpose of assisting them was experienced as a violation of privacy. However, when respondents were sick, tired, weak and in need of more assistance than usual, the nursing staff's ability to enter the private room single-handedly contributed to a sense of safety and caring. Building on the pragmatist underpinnings in grounded theory, constructivists believe that reality is constructed within social relationships, repeated performance and shaped by discourse (45,52).

Place possesses meaning through human agency, intentionality, essence, authenticity and embedded knowledge (31). An important aspect of the creation of attachment to place, as well as to construct privacy, is that of spending time alone in one's room. According to the pragmatist view of Pierce (9), the essence of beliefs (in this case, sense of attachment and privacy) is establishment by habits. Routines and rituals are important aspects of the home space, and according to our findings, domestic activities within the private sphere are important in constructing a sense of normality. One way to construct attachment to place is to mimic the idea of one's old home, and subsequently parts of one's old self-identity (7,8,12,53), signalling sociocultural values and interest. By decorating the room in a way similar to that of their

old home with private symbols, such as photographs and personal belongings, the residents claim a piece of the institution as their own, which bridged the gap between their old and new life situation. Another way of bridging the gap between one's old and new self-identity was to create attachment beyond the institution. The residential care facility was regarded as a 'hotel' where the nursing staff was experienced as prosthetic, acting like substitutes, compensating for lost abilities of the person.

There is a general agreement in the literature about the reciprocal relationship between well-being of older persons and their ability to experience place-attachment (6,12). The literature also shows that older persons with strong attachment are those most likely to successfully adjust to the contingencies of ageing (4,5,54). A sense of attachment to place is also a prerequisite for feelings of homeliness that enables older persons to draw meaning, security, sense of belonging and self-identity (12). The home place serves as a crucial material and symbolic source of biographical development and construction of self-identity (55). A related concept used in the literature to describe well-being among frail older persons in residential care is thriving, which is dependent on person-environment interaction, as well as beliefs and attitudes held by the older person (56,57). Quite obviously, place-attachment and thriving are closely related. However, according to our results, thriving is just one aspect of successful place-attachment. A consequence of the 'ageing-in-place' policy is that older persons moving to residential care today are more frail and dependent, in terms of decreased functional and cognitive capacity, than before.

The vast majority of Swedish residential care facilities are designed according to guidelines established in 1992 by the Community Care Reform, embracing purpose-built and small-scale environments, adapted to accommodate declining visual, auditory and kinesthetic senses (58), with single rooms and private bathrooms (1,2). Well rooted in our Western individualist culture is the assumption that status invariably derives from ability. Based on our findings, strategies used by older persons to create attachment require some degree of effort. In relation to the fact that those moving into residential care are more frail and subsequently less able to gather the strength needed for nesting and making new friends, the responsibility for facilitating attachment needs to be acknowledged by those in charge of the care provided.

There are apparent limitations in perceiving shared spaces as private. In general, public spaces offer opportunities for social interaction and participation in activities. It has even been proposed that the semi-public nature of the residential care facility would benefit from a reorientation in terms of enhancing the public aspects of the shared spaces (59). A clearer demarcation between public and private would not only support the creation of attachment to place, it would also provide less ambiguous signals to

nursing staff, which according to our findings were those that violated most of the privacy of the residents.

The central tenet of making new friends, and thereby create attachment to space, was that of having the ability to independently decide when and how to interact. It is well known that independence and control are prerequisites for quality of life (60). The neutral and permissive aspects of the shared spaces seemed to support social interaction, and entering each other's private rooms could be controversial even with an invite. The private room was clearly restricted to one's self, family, good friends and nursing staff with the intention to assist. In this study, those residents that were able to create attachment accepted their frailty and tried to make the best of things.

Limitations

The trustworthiness and authenticity of our findings need to be addressed. Qualitative research of all sorts relies on those who conduct it. A reflexive and consciousness stance informs how the researcher conducts her research, relates to the research participants and represents them in written reports (44–47). In this study, the first author (HF), a Registered Nurse with extensive experience of elderly care, conducted all interviews, which might have influenced the interviews. The credibility of our findings can partly be based upon the richness of the data. In this study, 25 older persons participated, of which nine were interviewed on more than one occasion. Each interview lasted between 20 and 80 minutes, which generated a range of detailed descriptions and multiple views of the informants' views and actions in constructing attachment and creating a home. Although our findings do not include explicit theory construction, it might provide a useful analytic framework to see this world as our research participants do – from the inside (45, pp. 14).

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Conclusion

Almost 15 years ago, Kahn (24) stated that those able to adapt to life in residential care were those recognizing the ambiguity of the environment, that is, being a place where they had to live until they died, getting as much satisfaction as possible from what remained of their lives. This duality will always remain in the context of frailty and old age. However, besides making the best of things, our findings move beyond the mental state and determination of older persons, and into the realm of practicality, action and strategies. By assuming that attachment and 'a place to call home' are of vital importance to human existence regardless of age, attention must be paid to optimize the conditions and circumstances under which attachment to place and space are created in residential care.

Author contributions

HF and KF designed the study. HF did all interviews. HF and KF performed the GTM analysis. LOP and HW provided critical guidance throughout the analysis process. HF wrote the initial draft. HF, KF and HW finalized the manuscript.

Ethical approval

The Regional Ethical Review Board at Gothenburg University, Sweden, approved the study (#572–06).

Funding

The study was funded by Swedish Brain Power, Karolinska Institute, Stockholm, Sweden and Tre Stiftelser, Gothenburg, Sweden.

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