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How staff act and what they experience in relation to the autonomy of older adults with physical impairments living in nursing homes

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Abstract

Autonomy is important for people, even when they have physical impairments and are living in nursing homes. The way staff respond to residents is important for the realisation of autonomy. In order to gain knowledge about what nursing home staff, registered and assistant nurses, occupational therapists and nutritional assistants do and experience in relation to the autonomy of residents, a qualitative study design was chosen. Shadowing, a non-participatory observation method, was used. A total of 15 staff members of a care unit from two different nursing homes participated. Short interviews followed these observations to reflect on intentions of observed activities. The COREQ guidelines were used to report on the study. Four activities to enhance autonomy were identified: getting to know each older adult as a person and responding to his/her needs; encouraging an older adult to perform self-care; stimulating an older adult to make choices; and being aware of interactions. The exploration showed that staff considered it important to strengthen autonomy of older adults living in nursing homes and that they used different activities related to autonomy. However, activities could both enhance as well as hinder autonomy.

Keywords

geriatric nursing, long-term care, prerequisites of staff, shadowing

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Introduction

Autonomy is seen as important for individuals, even when they are older and need help. Most older adults with physical impairments and chronic conditions continue to live at home for as long as possible, with the help of informal caregivers or community healthcare.[1] Older adults who need 24-hour care, and who cannot organise this care at home, can move to a nursing home.[2] However, living in a nursing home might influence autonomy.

Based on a systematic search of the literature, autonomy was approached in this study as the capacity to influence the environment and make decisions irrespective of having executional autonomy, to live the kind of life someone wants and desires to live in the face of diminishing social, physical and/or cognitive resources and dependency, and it develops in relations.[3]

In 1988, Collopy[4] identified several dimensions regarding autonomy in the context of long-term care, i.e. decisional, delegated, executional, authentic and direct autonomy. All dimensions can be seen in nursing homes; however, most studies concerning older adults with physical impairments focus on decisional and executional autonomy.[5] Decisional autonomy refers to deciding how to live in a nursing home, while executional autonomy refers to the ability to carry out these decisions independently.[4]

In the Netherlands, nursing homes provide 24-hour care for older adults with physical impairments and for older adults with dementia.[2] The residents live in separate units according to their condition.[6] Care is provided by registered and assistant nurses (hereafter called nurses).[7] Usually, nutritional assistants (NA) also work on the unit to provide meals, as well as occupational therapists (OT) who facilitate activities. An elderly care physician is responsible for the entire medical care of an older adult.[8]

Older adults, i.e. aged 65 years or older, with physical impairments due to age-related decline or chronic health conditions (hereafter referred to as older adults with physical impairments) generally do have the capacity to decide how they want to live their lives in a nursing home. However, they are often hindered in terms of executing these decisions due to the underlying physical conditions that made them move to the nursing home. To compensate for this lack of executional autonomy, older adults with physical impairments try to maintain autonomy by active involvement in how, when and where daily activities take place.[9,10]

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Whether their active involvement is successful depends on how nurses and other staff react to the verbal or non-verbal expression of the wishes and needs of older adults.[11–13] The literature reveals that the way care is given can act as either a barrier to or as a facilitator of the autonomy of older adults with physical impairments in nursing homes. Nurses who are familiar with and work with individual strategies to maintain the autonomy of older adults themselves and listen to their life stories can enhance autonomy.[11,14] The absence of effective communication skills in nurses can act as a barrier to autonomy (e.g. when routines dominate or activities are imposed on residents).[15–18] The attributes of nurses, such as ethical competence and creativity, can act as a facilitator of autonomy.[12,19] Conversely, ageist assumptions and ageist communication are barriers to autonomy.[10,20]

To deepen our insight into how staff react to the expression of wishes and needs, the authors wanted to explore and describe how staff act and what they experience in relation to the autonomy of older adults with physical impairments living in nursing homes, in daily life in care units.

Methods

To explore and describe how staff act and what they experience, a qualitative descriptive design was chosen.[21] Shadowing was used, which is a phenomenological method to explore and describe the reactions of staff towards autonomy with non-participatory observation.[22] The researcher followed a participant who was performing diverse activities over a period of time – in this study, parts of one dayshift of 8 hours. Shadowing provided detailed data because actions were observed and participants did not only give their verbal opinion about why they acted in a certain way. Another advantage was that it provided holistic information because it also revealed unconscious activities. To understand the intentions of activities and interpret what occurred during the day, a brief recorded interview with the participant was conducted.[23] Questions that were asked included 'How important is autonomy to you?', 'How important is autonomy to the older adults you care for?', 'Can you enhance autonomy in your work in this unit?' and 'Which situation today is the best example?'

Table 1. Description of participants and data collection.

	Unit A	Unit B
No. of shadowed staff and gender	8 women	7 women
Mean age (years)	43 (21–64)	37 (21–57)
Function	Occupational therapist: 1 Nutritional assistant: 1 Registered nurse: 1 Assistant nurse: 4 Nursing student: 1	Occupational therapist: 1 Nutritional assistant: 1 Registered nurse: 2 Assistant nurse: 3
Mean time working in the unit (years)	9 (0.5–28) One missing value	8 (1–20)
Observed organised social activities	3	2
Observed morning care	14	13
Observed mealtimes	16	17
Observed breaks/ reporting time and handover in the nurses' office	4	7
Mean interview time (min)	9 (4.58–16.49) One missing value	7 (4.48–11.13)

Values in parentheses are range.

To report on the quality of the study, the Consolidated criteria for Reporting Qualitative research (COREQ) guidelines were used.[24]

Context and setting

Two nursing homes in the southern region of the Netherlands agreed to participate in the study. Both nursing homes stated in their mission that they aimed to support the autonomy of their residents. In each organisation, one unit, A and B, was selected to participate in the study. Unit A was part of an organisation that provided care in a large town (200,000 citizens) and offered places to 40 older adults with physical impairments and employed 25 full-time equivalent (FTE) staff. Unit B was part of an organisation serving a small- (23,000) and medium-sized (36,000) town and the surrounding area. This unit employed 23 FTE staff and cared for 28 older adults with physical impairments living in the unit.

This study investigated staff members, i.e. nurses, NA and OT, who were working on one these two units.

Recruitment/sample

Purposive sampling was used, in which the authors selected participants who had knowledge and experience with the phenomenon.[25] Beforehand, the authors aimed to shadow 10 individuals per organisation to ensure reasonable coverage of variation. To shadow diverse activities in which autonomy can be observed, such as morning care[6] provided by nurses, organised activities[10] facilitated by OT and meals[16] served by NA, individuals in these various positions were contacted. The researcher made contact with an informant working on unit A or B to talk about recruitment and the study procedure. After this, she informed the staff about the aim and design of the study in a regular team meeting for units A and B. The staff were invited to participate in the study; information and an informed consent form were given to them. There was a two-week period for the staff to read the information, consider participation, ask questions and return a signed copy of the informed consent form. The informant was available to answer the questions of colleagues and share this information with the researcher.

Of the 16 persons who decided to participate in the study and signed the informed consent form, 15 actually participated. On arrival to the unit, one person who had agreed to participate was scheduled to work in another unit.

As shown in Table 1, the age of the participants in unit A was in the range of 21–64 years (mean age 43 years). In unit B, the age range was 21–57 years (mean age 37 years). In both units, only female staff participated, which reflected the gender distribution on the units. In unit A, staff worked for

half a year to 28 years (mean 9 years), and in unit B, from 1 year to 20 years (mean 8 years). Each staff member participated in the shadowing for approximately 4 hours, and on average spent 8 minutes (range 4.48–16.49 min) in the concluding interview. One interview is missing due to a misunderstanding.

Data collection

Possible shadowing dates on various days of the week, Sundays and public holidays over three months from April 2017 to June 2017, were suggested to participants of both care units. They could choose a date that fit their work schedule. For shadowing, the dayshift was chosen because morning care, meals and activities were planned during the day. Furthermore, NA and OT only worked dayshifts. The first author (JvL), who is a female registered nurse, collected the data.

On unit A, eight registered or assistant nurses had dayshifts starting at 7:00 am or 8:00 am, and on unit B, there were six nurses working the dayshift. The researcher informed the staff after arrival on the unit who she was and who she was going to shadow that day. The researcher as shadower closely followed the participant during the day. In total, 76 situations were shadowed, such as morning care, mealtimes, organised social activities, walks from one room to another, breaks, reporting and handovers in the nursing office. During these breaks, meals, reporting and handovers, the researcher could observe in what tone or words was spoken about the residents' preferences and wishes and the granting of them.

During the shadowing, the researcher tried to be like a fly on the wall. She tried to stay outside the field of view. However, she moved along with what happened, she entered the apartments of the older adults with the participant, ate lunch in the same space and engaged in small talk when this was considered to be more comfortable in the situation.

In the course of shadowing, the researcher made field notes of everything that happened, such as conversations and non-verbal expressions, complemented with contextual information, such as knocking on the door, waiting to enter the apartment, smells and the position of the participant. Although the literature provides general information about facilitating and hindering activities of staff towards autonomy, an inductive way of collecting data was chosen. Ahead of time, it could not be known what would be seen during shadowing and which activities, after analysis, would be identified as directed towards autonomy.

The brief interviews after the shadowed shift were recorded. The field notes were typed out in observation records, and the recorded interviews were transcribed on the same day. The observation records and interview transcripts of each participant were combined in one report to study the observed activities, together with the stated intentions.

Data analysis

The researchers started with an individual reading of the observation report of one participant, and they used open coding to code the text fragments. Afterwards, these four authors (JvL, BJ, IdR and KL) discussed the interpretation of the text fragments, exchanged their views in a meeting and decided on the appropriate codes. After coding and analysing one report with four authors, co-coding was carried out in pairs of researchers. JvL coded all 15 reports, while BJ, IdR and KL each coded four to five reports. After 10 co-coding sessions, similarities and differences in coding were discussed in a meeting with four of the five authors (JvL, BJ, IdR and KL). This led to the revision and/or refinement of codes. The same was done after the last report was coded.

After consensus was reached concerning the names of the codes, the fragments with codes were processed using ATLAS.ti version 8. This tool offered the opportunity to summarise the codes in groups and to check, discuss and adjust them a final time. In the writing process, ATLAS.ti was used to describe the results and search for suitable quotes.

After the coding was finished, two authors (JvL and MJ) analysed the data thematically. Together, they followed a procedure of finding, explaining and describing patterns and their meanings within the data.[26] The codes that were about a similar way of enhancing autonomy were grouped in the main codes in ATLAS.ti. A name was given to the overarching theme of one or more main code(s). In this way, an answer to the research question could be provided. All researchers discussed the analysis until consensus was reached regarding the themes.

Box 1. Coding tree for theme I.

Getting to know each older adult as a person and responding to his/her needs

1. *Working together as a team in the unit*
   - Focussing on the preferences and wishes of the older adult
   - Searching for opportunities to answer to needs and wishes
2. *Involving family and friends*
   - Acknowledging the role near ones (want to) have
3. *Knowing needs*
   - Inquiring needs anyway
   - Knowing structural needs about morning care, meals, activities, aids, cloths, personal items
   - Responding to incidental needs
4. *Having talks*
   - Chatting about mutual background
   - Chatting about the background of the resident

Box 2. Coding tree for theme II.

Encouraging aspects of self-care

1. *During morning care*
   - Inviting to wash, dry parts of the body
   - Inviting to comb the hair, put on make up
   - Inviting to dress themselves (partly)
2. *During eating and drinking*
   - Inviting to eat independently and butter bread
   - Inviting to poor coffee and tea
   - Not giving the chance to prepare food (this is done in the kitchen)
3. *During activities*
   - Inviting older adults to participate according to their possibilities
   - Inviting older adults to help each other
   - Not giving choices to older adults and taking over when something is not carried out properly

Box 3. Coding tree for theme III.

Stimulating older adults to make choices

1. *Around morning care asking to make choices about*
   - where, when, and how morning care will be provided
   - care products
   - which clothes to wear and how hair is done
   - whether or not to wear the clothes again
   - when and where going to the toilet
   - pace, stopping, continuing with care, order of care
   - the use of mobility aids
   - subjects even if there is no preference
2. *Around mealtimes asking to make choices about food and drinks, the amount of food and drinks, where and when to eat*
3. *During individual/group activities asking to make choices about how to carry out the activity*

Box 4. Coding tree for theme IV.

Being aware of interactions

1. *Way of behaving towards the older adult*
   - Asking permission to do something
   - Giving compliments and feedback
   - Thinking out loud, checking the preference of the older adult
   - Announcing care activities
   - Responding to non-verbal communication of older adult
   - Responding to signs in communication of older adult
   - Using inclusive language
   - Using humour
   - Convincing and patronising
   - Using task-oriented communication
2. *Using empowering interactions*
   - Encouraging the residents to stand up for themselves
   - Standing up for known preferences of older adults
   - Facilitating mutual contacts between residents and family
3. *Working from a set of values about autonomy*
   - Combining care activities with personal attention
   - Being aware that enhancing autonomy has positive effects for the nurse as well
   - Being a role model (senior nurse, having quality as field of attention)
   - Seeing autonomy as a right
   - Respecting choices made
   - Not responding to preferences of older adults in order not to have to make an exception

Ethical considerations

The Ethical Review Board of the Tilburg School of Social and Behavioural Sciences of Tilburg University (registration number EC-2016.62) approved this study. Moreover, this study was performed in compliance with the Declaration of Helsinki[27] and regulations on data protection, i.e. all methods were carried in accordance with the relevant guidelines and regulations.

The Ethical Committee of unit A (dated 16 December 2016) also gave permission for this study. Unit B did not have such a committee, but the management board approved the study (dated 23 November 2016).

Older adults, their first contact person and volunteers on the unit received a letter with information about the study. They were not included in this study, although they were present in the context during data collection. The researcher informed individuals she met during the shadowing verbally. No personal data were collected about them.

To consider specific and implicit assumptions and values concerning autonomy and how these could influence the study, the first author, as a researcher and a nurse, reflected regularly (before and during the study) on her role with a mentor who was not involved in the research. She repeatedly wrote down and shared these insights with the other authors.

Findings

The thematic analysis resulted in four themes, which are described below and illustrated with fragments of the observation records and/or interview transcripts.

Getting to know each older adult as a person and responding to his/her needs

Staff tried to get to know each resident as a person. This was seen in various ways. They behaved as if they knew the older adult. They talked about topics, such as where the older adult used to live, his/her former profession and the reason for admittance to the nursing home. They used dialect when suitable and used a first name when this was decided upon and approved by the older adult. They showed they were aware of and acknowledged the role of family and friends for the resident.

Knowing the needs of an older adult was observed during morning care. Nurses knew the preferences of the resident with regard to when they get out of bed in the morning and the place for morning care (bed or bathroom), care products, the order of care activities and the way activities should be carried out. They provided care with remarks such as, 'I know you like to get up early, that's why I start my shift helping you'. Staff showed that they knew whether the older adult used hearing aids or wore glasses. They offered those before starting a conversation. It was observed that staff knew which activities were preferred, such as taking a walk in the garden, spending the weekend with family, listening to music or joining an organised activity. As a part of small talk during the day, they referred to these activities, 'Are you going to visit your wife today?' or 'The weather is beautiful. Are you going out today'? Furthermore, staff showed they knew where, with whom and what older adults liked to eat.

Notably, the observation that, although the participants knew these needs, they still asked the residents for their preferences to check. In the interviews afterwards, they explained that they used this verbal check to involve older adults in the interaction or to check whether preferences had changed. Participants also aimed to reassure residents that they knew what the resident preferred. They intended to prevent stress. For example, a nurse used verbal checks on every step of morning care with a resident who had aphasia; this made the resident feel better because she knew that morning care would be provided following her wishes.

> Participant A2, told in the interview, 'I know [name], do you see the blouse hanging there? It is meant for today, everything is laid out there, combined with this necklace, and everything is prepared. Her husband tends to this every evening. I know this is what she wants to wear. Nevertheless, I always check, "Is this what you want to wear?" I let [name] be involved. I think this is important.'

> In an observed conversation, a resident said, 'The nurse of the nightshift didn't turn me tonight. You always do'. Participant B7, 'You asked me to wake you up and turn you, even if you are fast asleep. I reported that the others do this as well.' 'It is not necessary,' the resident answered. Participant B7, 'You wanted it so I act upon it. It is better to prevent pressure as well.' The resident said, 'Then please do so, I always easily fall asleep again…I sleep so well.'

Knowing the preferences of the older adult and responding to it was not always possible. In the interviews, nurses reflected that they have to work within the conditions of the care environment that might act as barriers to enhance autonomy. Nurses felt understaffed to respond to the call system in a timely fashion or help with going to the toilet on time; they did not have enough time to respond to needs in a proper way. One nurse mentioned that if she took the time needed to offer choice and act upon these choices, she had to cope with the comments of her colleagues who had to work harder or with the comments of her family at home when she arrived late from her shift.

Participants stated in the interviews that not every colleague was sensitive to the needs of an older adult. For example, instead of taking a resident out for a walk on a day that the work was done early, some nurses spent their time drinking coffee in the sun together with colleagues.

Encouraging aspects of self-care

Nurses invited older adults to take an active role during morning care, washing and drying their face, hands, arms and/or upper body, combing their hair and putting on clothes. They gave compliments when an older adult did this spontaneously. In several observations, it was seen that nurses gave older adults control over their appearance by placing them in front of a mirror and asking to comb their hair.

> The resident said, 'I do everything that I can do myself.' Participant B7 replied, 'You can start washing yourself; I will leave you for a moment because somebody else needs help.' On her return, she asked, 'Is everything OK? I see your hair is already done, shall I proceed with washing your back and the other arm?'

> In the interview, participant A6 gave an example of autonomy enhancement. 'The morning care of [name]. I asked her to wash her face and to put on some clothes herself. She decided herself how long she wanted to stay on the toilet. I see the decisions about what she can or cannot do herself as autonomy. I take over the "pieces" she can't do. The rest is up to her. Did you see she could raise herself up? I did not even have to help. My colleague offered assistance with the transfer, but I wanted to see what happened. [Name] did it herself, another thing that she did independently today.'

Sometimes, nurses did not seem to be focused on the wishes of an individual resident regarding self-care and the actual context. Comments from nurses to older adults, such as 'It is good to keep doing all you can do' and 'We share the work', were commonly heard during the observations. However, nurses did not check if older adults wanted to do these activities themselves or how the older adults wanted to spend their energy during the day. In the interview after shadowing, in which the participants were asked how they related to the autonomy of older adults in their unit, some staff referred to autonomy as being independent and doing things themselves.

In unit B, older adults had an active role during breakfast and lunchtime when they ate in the living room. The table was set by the NA and they could take bread, butter, spreads, cheese and coffee or tea themselves. The NA encouraged the older adults to prepare their breakfast themselves and help each other to pass the butter and spreads or pour tea. After the meal, older adults helped to clear or clean the table. In unit A, self-care during mealtimes was not encouraged. Residents were asked what they would like to eat and then it was prepared in the kitchen by the NA.

Stimulating older adults to make choices

During the observations of morning care, nurses provided many choices about where to wash: on the bed; in the bathroom; or whether or not to shower. In addition, choices were given about the time of care and the order and place in which activities were done. Furthermore, the choice of care products, such as shower gel and deodorants, was seen. Residents were invited to choose which clothes to wear and how they wanted their hair styled. Nurses often offered a choice about when the resident wanted to go to the toilet, i.e. before, during or after the care was provided.

After morning care, nurses gave the option to have breakfast in bed, in the apartment or to eat in the unit's living room. The NA offered a choice of breads, spreads, porridge, dairy products and drinks. The products were shown to point out the choice or verbally listed until a non-verbal reaction was observed. During the observation, the shadowed NAs mentioned that, although they knew the answers, they kept on asking about the preferences of the residents about their meals. When the older adults of unit B ate breakfast in the living room, the food was presented in such a way that residents could take the items of their choice themselves.

> Participant B3 stated during the interview that every resident had a book with 100 warm meals. It changed every season. On Sunday, residents could hand in their choice for the next week. They could fill in the preferences themselves or ask their family or friends for help. There were photographs, so even residents with aphasia could point out their choice. If needed, a member of the staff helped.

However, this system of choosing individual meals had a disadvantage; residents could not choose fresh ingredients, such as salads, because the supplier did not provide them. Not every choice was granted, e.g. the NA could not offer a soft-boiled egg, because this might negatively impact the health of the residents. An NA chose the two soups of the day and was aware that not everyone would like the options. She justified this by referring to a normal family in which only one soup is prepared.

Residents were members of different preferred 'clubs', for example music, painting, walking and cooking clubs. These organised activities were often scheduled weekly and were facilitated by the OT. Other activities were proposed on an individual basis.

> Participant A7 asked the resident, 'Would you like to take a walk with me this week? Perhaps Wednesday?' (..) 'Do you wish to go for a walk? We can also choose something else.' The resident mumbles. 'Perhaps you can think about it? We can also go to the garden together and have a drink.'

The OT invited residents to make choices while engaging in activities, e.g. to peel potatoes or clean strawberries. At the end of the cooking club, the menu to be cooked next week was chosen by the older adults. The OT invited all participating residents to mention what they liked to eat most

Being aware of interactions

Some nurses announced every care activity verbally, such as 'can you lift your leg'. Others used the time they spent with older adults during morning care to talk about subjects, such as living in the nursing home or the loss of a child. Often, small talk was used, concerning the life of the older adult or a mutual background. Staff also invited residents to share their knowledge and experience. For example, the OT invited a resident with a high spinal cord injury to lead the preparation of a cheesecake in the cooking club. Although the resident could not use her hands, she led the group activity. Empowering communication was seen when staff advised residents that they really should express their needs, such as asking for help to go to the toilet or sharing opinions about how care was provided in the unit.

When interacting with persons with aphasia, hearing impairments or a non-native speaker, non-verbal communication was used to determine the wishes of the older adult. Nurses asked residents deliberately for permission to do things, such as opening or closing curtains and windows, turning on the light or putting dirty clothes in the laundry. Nurses respected choices if no permission was given on these matters. The OT aligned with what happened without a plan of her own, adapting her pace and slowing down. She showed confidence that the resident would succeed.

> Participant B6 helped a resident with an email. The computer was working slowly. The resident was upset. Participant B6 stayed calm; she asked permission in every step she assisted with, 'May I look here?'

Often, staff used humour to break the ice, to ease tensions and to wave aside feelings of shame, for example when someone was too late to ask for help with toileting. Sometimes, this way of interaction did not seem to be effective.

It was also observed that two nurses provided care to an older adult while talking to each other about subjects as coordinating care activities, leaving the resident as an object of care.

Moreover, patronising communication was seen, for example when the cheeks of an older woman were pinched or words such as 'love' or 'dear' were used.

Some of the nurses referred to organisational issues regarding whether to take an active role in autonomy enhancement, as it was not in their job description or not expected based on their level of expertise. In addition, they defended themselves by saying they could not make exceptions to the rules to give someone a choice.

> It was lunchtime and most of the residents were in the living room. One resident called loudly for a nurse that she needed to go to the toilet. Participant A5 approached her and said she was responsible for the lunch and therefore she could not help [name] to the toilet.

Other participants were very explicit about their values and standards, and they tried to preserve and enhance autonomy. Given the circumstances, they did their best (e.g. they often stayed longer than scheduled). They left with a good feeling about their shift if they were able to give all residents the care and attention that was needed that day. They tried to improve aspects of the care environment to enhance autonomy (e.g. addressing understaffing, expressing their views on autonomy to the team or taking an exemplary role as a head nurse or as a person).

> In the interview, participant A3 reflected on what she knew about autonomy. 'In the first year of the nursing education, there is a lot of emphasis on autonomy. School teaches the importance of, when it is safe, giving patients choice and independence. Only if it is safe, otherwise you have to act as a nurse. (…) Personally, I give residents a choice, if they can; they have a right to do so. (…) If I cannot understand what they want, I use non-verbal communication: looking at facial expressions, nodding, just seeing how they react. (…) Staff that are working on routines take over very quickly. It is easy, the work is done faster. However, it is not my way of working; I try to stand up for my opinion on this.'

Some nurses said they did not see others enhancing autonomy. They mentioned some of their colleagues following their own preferences on who to help first in their shift or trying to have everyone 'out of bed' before the coffee break.

Discussion

In the study on the actions and experiences of staff, four activities were found in relation to the autonomy of older adults. Staff were concerned with getting to know the older persons and meeting their needs, encouraging self-care, stimulating choices and were aware in interactions.

The study showed that staff do consider it important to strengthen autonomy and used various activities to get to know

the older adults and strengthen their autonomy. It was seen that some staff were unconsciously using autonomy-enhancing activities, although they were not aware of this, and that they acted in a different, more autonomy-enhancing way than their colleagues. Having limited time sometimes led to a situation in which staff did not even try to respond to residents' needs. Routines and time schedules to provide care sometimes seemed to prevail above the needs and preferences of residents. This has also been described in other studies,[12,20] in which safety and physical care were seen as more important than autonomy. However, the theme of being seen as a person is also recognised as being important to the dignity of older persons.[19] Advice for staff is to be sensitive to situations in which a lack of time is experienced, to respond to needs and to address this problem with colleagues.

Two underpinning approaches to the autonomy of older adults, i.e. executional and decisional autonomy, were also found in the activities of staff. Encouraging aspects of self-care reflected the executional dimension of autonomy: being able to make decisions and to carry them out.[4] Self-care was emphasised, without verifying whether this was also the preference of the resident. Orem's model for nursing, with self-care theory at its core, has been taught in nursing education for a long time. Therefore, staff had learned to help residents to do as many things as possible themselves. Only when this was no longer possible did nursing interventions seem appropriate.[28] This was exemplified by participant A3 who stated: 'When it is safe, you give residents choice and independence, but only when it is safe; otherwise, you have to act as a nurse.' However, self-care has been found to be a one-sided view of autonomy as independence, which can hinder autonomy.[11] Facilitating self-care seemed to be a helpful activity for autonomy if it was done in accordance with the residents' preferences.

Stimulating residents to make choices themselves refers to decisional autonomy, i.e. the ability and freedom to make decisions without external persuasion or restrictions.[4] In the current study, it was seen that staff who gave choices to residents in care or social situations achieved a positive effect on choice. For residents who were able to make decisions about participating in social activities or clubs, the feeling of being in control was increased. This was also seen in a study on social activities in a nursing home.[10] Maintaining a resident's autonomy through respecting choices such as clothing and food was also found by other authors.[19] Offering choices in day-to-day life was frequently used and seemed to be an effective activity to maintain autonomy.

Awareness of interactions was seen, which can enhance autonomy, but this was not always the case. In the current study, patronising communication was also found, which is a way of communicating that can hinder the mutual characteristics of interactions. This was also found in a previous study to be a barrier to the autonomy of older adults.[29] Communication should therefore be used consciously in order to enhance residents' autonomy. For this reason, a reciprocal relationship between residents and staff is important and of added value.

Strengths and limitations

The aspects of credibility, reflexivity, confirmability and transferability were taken into account to heighten the trustworthiness of the study. Lincoln and Guba, as cited in Korstjens and Moser, suggest these as quality criteria for qualitative research.[30]

Using the method of shadowing proved to be insightful. The researcher intended to see unconscious behaviour, and this was found to be the case (i.e. unconscious activities that enhance or hinder autonomy were observed). In the interviews, the researcher noticed that participants were not always aware of the activities they used and actually did enhance autonomy. The triangulation of methods, the combination of non-participative observations and short interviews to clarify the meaning of the observed behaviour strengthen the credibility of the study.[30]

This study explored and revealed the experiences and activities of the staff on two units in two nursing homes in relation to autonomy. The description of the context and participants in the study may help others to understand the applicability of the findings in their own context. In this study, the effect of these activities on the autonomy of older adults was not established (this was not the aim of the study); nevertheless, it provided insight into which activities might have a positive influence on enhancing the autonomy of older adults in nursing homes.

One measure to increase credibility was the prolonged engagement during the observations. To prevent bias, the other authors, not being nurses, were alert to implicit assumptions and noted them while discussing the fragments in group meetings.[30]

To ensure that the interpretation was grounded in the data, the confirmability, the process of co-coding with three other researchers and consensus meetings were used to analyse the data. The four researchers reached consensus about the codes. A fifth researcher (MJ) and the first author (JvL) thematically analysed the data. This resulted in the four themes of activities found in this study. The researcher was able to shadow 76 day-to-day situations, including care situations, mealtimes and activities. This provided no new information after 15 days of data collection. The researchers did not recruit more (of the intended 20) participants because data saturation was reached.

Implications and recommendations

Awareness of the four activities found in this research can help to enhance the autonomy of older adults with physical impairments living in nursing homes. This knowledge can be used in learning activities with the aim of improving care. Conversations between staff and older adults about how they perceive autonomy can be organised. To become more aware of activities that stimulate or hinder autonomy, staff can shadow each other to become more conscious of activities colleagues use in relation to autonomy and reflect on these together.

This study focused on the experiences and activities of staff members in relation to the autonomy of residents. This cannot be separated from the way in which the older individuals maintain autonomy themselves and the way in which family and friends support or hinder autonomy. It is advised to look at the needs of older adults and whether the activities of staff lead to more autonomy. Further research into mutual actions and interactions to enhance autonomy is recommended.

The care environment, in which older adults and staff interact, influences the activities and intentions of staff. Further research into barriers and facilitators in the care environment

regarding autonomy (e.g. the potential for innovation and risk taking, the appropriate skill mix and the physical environment) is recommended.

Author contributions

JvL collected the data. JvL, BJ, IdR and KL coded the observation reports and transcripts. JvL and MJ themed the codes. All the authors interpreted the findings and were involved in the drafting and revisions of the manuscript. All authors approved the publication of the article.

Conflicting of interest

The author(s) declare that there is no conflict of interest.

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