Identity-supportive care of patients with dementia disease in nursing homes

Abstract

This article is based on interviews with 14 carers and managers in nursing homes in northern Norway. It discusses how an awareness of an individual's earlier life is expressed in person-centred care, and how this influences the patient's life in the nursing home. In this context documentation, professional development, and the organisation of the nursing home are also discussed. The analysis and discussion are based on the theoretical concepts of identity, continuity, and person-centred nursing. The results of the study highlight the importance of reinforcing a sense of belonging in the patient with dementia disease. The value of nursing home staff having local knowledge is emphasized. Before a person moves to a nursing home it would be useful for staff to visit the person's home, gather information from the person and their family, and establish a relationship that can give a sense of security. In the nursing home a feeling of belonging and identity can be enhanced through daily activities, personal care and mealtimes. Ongoing competence building in the nursing home is important.

Keywords

Vulnerability, elderly people, life course, person-centred nursing

Introduction

The paper discusses the care of patients with dementia disease in nursing homes in northern Norway and how it is possible to support a feeling of continuity and a sense of identity. Patients should have the opportunity to cultivate their interests and be ensured a decent and meaningful life (Helse- & omsorgsdepartementet, 2010, 1988). Carers' and managers' familiarity with the life stories of patients with dementia disease, and how this knowledge affects the patients' life in the nursing home was investigated. There is a focus on how to

sustain continuity between the patient's earlier and present life.

Many studies have shown the significance of understanding the patient as a person (e.g. Wadensten, Engholm, Fahlström, & Hägglund, 2009; Cohen-Mansfield, Parpura-Gill, & Golander, 2006; Moos & Björn, 2006; Brodatry, Draper, & Low, 2003; Zingmark, Sandman, & Norberg, 2002; Cohen-Mansfield, Golander, & Arnheim, 2000). Their findings indicate that individual care, including activities that the patient previously preferred, reinforced the sense of identity of patients with dementia disease.

Care of patients with dementia disease

Identity and continuity is linked to both internal, emotional processes, and external circumstances (Drageset, Normann, & Elstad, 2013, 2012). Internal continuity is related to feelings, values, preferences and a sense of being connected to the past. External continuity is related to physical and social surroundings, roles and activities (Fossland & Thorsen, 2010). External identity defines the person, while the internal identity is related to values: where we are in life, what we are, and what we believe in (Erikson, 1968). Kroger (2007) points out that identity is flexible, that a person's life experiences can change them. In old age a person's identity and continuity can be challenged by dementia disease (Fossland & Thorsen, 2010; Kroger, 2007). As the disease advances, it can become difficult to remember the experiences that have formed one's identity (Drageset et al*.,* 2013; Brooker, 2007). Carers need to know, and uphold, the important stories from the patient's life (Brooker, 2007).

This study is based on a person-centred approach to caring for patients with dementia disease, where the focus is on the patient's life story, habits and values (McCormack, 2004; Brooker, 2007, 2003; Kitwood, 1997a, b). Person-centred care for a patient with dementia disease

means that the person is valued, their rights are safeguarded, their perspective is appreciated and their subjective experiences are recognized (McCormack, 2004; Brooker, 2007, 2003; Kitwood, 1997a, b, 1995). Functional relationships are crucial in person-centred care (Brooker, 2003). This means that both patient and carer are valued and respected (McCormack, 2004; Kitwood, 1995). Martinsen (2005) argues that relationships and dependency are fundamental in discussing values, and that care has relational, practical and moral dimensions. Knowledge, skills and organisation are essential for the carer to meet the patient (McCormack & McCance, 2010; Martinsen, 1989). Managers have a responsibility to value and respect staff, and give them the means to implement person-centred care. It is important to be aware of the challenges the patient with dementia disease faces (e.g. Wogn-Henriksen, 2012; Hoe & Thompson, 2010; Cohen-Mansfield et al., 2000; Kitwood, 1997a).

Methods

Fourteen persons were interviewed. The interviewees were from two nursing homes in northern Norway, one in an urban setting and one in a rural area.

Participants

The participants were managers at institutional and unit level, and carers from four units. All the participants were female. Two of the units were special units for patients with dementia disease, the other two units housed patients both with and without dementia disease. Participants were asked about their knowledge of patients' backgrounds, and what consequences patients' earlier lives had for their life in the nursing home. Documentation, information gathering, relevant competence development, and the organization of the nursing home were also discussed in the interviews. Participants were recruited by managers in each nursing home. The managers had worked in nursing homes for over ten years. Carers' work experience varied from 3 to 22 years, the average was 12 years. Both younger and older carers

participated. Participants read the interview guide before the interview.

Focus group interview

One focus group interview was conducted (cf. Wibeck, 2000) with eight carers from the rural nursing home. The focus group interview at the urban nursing home was not conducted due to staff absence. The focus group interview allowed participants to reflect over their experiences together (cf. Wibeck, 2000) in a dialogue that allowed experiential knowledge to emerge.

Interviews

Individual interviews were carried out with two managers and two carers from the urban nursing home. Two managers from the rural nursing home were interviewed together.

Analysis

The interviews were analysed using content analysis (cf. Graneheim & Lundman, 2004). The first and third authors examined the content analysis to corroborate the interpretation of manifest and latent meaning.

Insert table 1 and 2

The theoretical background for the analysis consisted of the terms: life story, identity, continuity and person-centred nursing. Special attention was paid to themes that were connected to the theoretical framework.

One weakness of content analysis is that the themes may become too general. Descriptive statements and examples can disappear in the analytical process. We have therefore chosen to illustrate the presentation of our results with quotations that highlight the individual and

contextual, which is the essence of person-centred care. Together with the theoretical framework and the contextual understanding, the quotations reinforce the interpretation of the interview material, which is itself relatively limited.

Ethical considerations

The project has been approved by the Norwegian Social Sciences Data Service (Norsk Samfunnsvitenskapelig Datatjeneste, NSD).

Findings

Local personal acquaintanceship

Personal acquaintanceship in small municipalities

The rural municipality was small, and those in administration had personal knowledge of the elderly who needed help. Managers believed that this protected the nursing home against cutbacks, and meant that the value of their work was recognized. Because the managers had worked many years in the nursing home, the local inhabitants knew who they were; “and you put more effort into finding good solutions”. They said “we survive because we know the people.” Some members of staff in the rural nursing home usually knew the patient before the move to the nursing home. The relationship was usually better when the patient was helped by a carer he or she already knew, than when the carer was a stranger. Many patients had also previously visited the nursing home.

The carers from the rural nursing home explained that a person who became a patient in the nursing home deserved to be met with dignity and respect, even when the earlier relationship had not been good. It could be challenging to know the patients' background:

> The disadvantage is that you get to know about those who have behaved badly, the man who has always drunk too much, or who beat his wife. It is difficult to meet a

> new patient with an open mind if you have already heard all the gossip from the whole of our little community.

One manager stated that some patients had never been social, and did not wish to be social in the nursing home.

Valuable competence

The managers in the rural nursing homes recruited and trained many carers from the local area. They valued the familiarity the carers had with the patients, local history and traditions. Both nursing homes worked with local volunteers, nursery- and primary schools. The urban nursing home invited relatives and local people to events in order to recruit volunteers.

The patient's life story

Documenting the patient's life story

Local knowledge was not emphasized by the participants from the urban nursing home. They cited the patient, family members, and professionals from other institutions as sources of information about the patient's life. They observed the patient and collected information as needed.

Both nursing homes documented the patient's family circumstances, names of close family members, health, functional level, where the patient had lived, what they had worked with, hobbies, religious beliefs and habits related to the demands and activities of daily life. The names of parents and siblings were especially important to allow carers recognize them when the patient talked about people from the past. One carer thought it was important to know about traumatic events in the past. This could be important if the patient became anxious without an apparent cause. In relation to documentation of the patient's social situation and function they emphasized that it was important to know how the patient got on with others.

It was said that new carers found it difficult orientate themselves, because the information about patients could be insufficient for the carer to understand the patient and give appropriate care. Some patients could not or would not give information about their past. One carer said: “We often have to feel our way to find out what they like and don't like ...” It was impossible to document everything in the care plan. Information was also exchanged informally between carers.

Cooperation with family members in documenting the life story

Staff in both nursing homes encouraged relatives to fill out a form with the patient's life story; “my history,” with comprehensive information about the patient's life, childhood, confirmation, profession, interests, events and “things we should know”. The form was often not filled out as the carers might have wished. They discussed whether the form was difficult to fill out, whether relatives needed guidance from carers, or whether a concrete example would help. Relatives were also asked to make albums with photographs from the patient's life and of family members.

The significance of the patient's earlier life in the nursing home

The patient's identity and development of dementia disease

One carer said: “what they've worked with is easily seen.” She meant that one could see from the body and behaviour of the patient whether they had worked hard physically, had been fishermen, nurses or had other employment. A manager described a woman who loved flowers, who watered the flowers and picked flowers for the tables in the summer. Many of the patients were used to being out of doors: “There is a lot of sitting inside now, for those who once liked to be outside.” One carer pointed out that it was unsatisfactory for a patient who had been used to being in the open air to be left sitting in a room without a view.

Several carers said that patients did not wish to join in activities they had earlier enjoyed, saying that they had worked all their life and wanted to relax, to be left alone and not have to join in the activities ...” One carer said “It's not easy to get patients with dementia disease to join in with activities. It seems like they don't want to...”

Patients were seen as people with ingrained habits who have “lived their lives in this way or that”:

> The patient can have sleeping problems. He can wake up in the night and be very restless, wander around and wake the other patients. The cause can be something small, maybe he is used to sleeping in a dark room and can't sleep with the light on. Maybe he is used to wearing pyjamas and when he doesn't have them he can't sleep.

It could be difficult for patients to maintain their interests and habits in the nursing home: “The life that the patient has had in their own home is changed.” The patient may have lived alone through a long life; in the nursing home they have to become accustomed to the other patients. This was difficult to understand for patients with dementia disease, and conflicts could arise.

The significance of familiarity for calm, well-being and conversation

The carers and managers in the rural nursing home thought that familiarity with the patient's background promoted calmness, conversation, well-being and a good atmosphere in the unit. One manager summarized that knowledge of the patient's life story was important to “give them a richer life in the nursing home, bolster their self-image and affirm them in what they have been before (…). You are familiar with how people earned a living, serious accidents, the names of the boats and church weekends.”

To initiate good conversations, it was important to know what each patient was interested in. The managers in the rural area explained that when the patients sat together at the breakfast table, the conversational themes could be related to the season, for example berry picking. They also said:

> When patients with dementia disease have a problem with language and only remember certain things from their past, then if you know the patient well through a long life, sometimes one word is enough for you to understand what they want to say.

They emphasized the carers' practical experience in the social space between patients:

> The staff is very important in the dialogue that takes place. They are the buffers. Patients with dementia disease seldom take the initiative to talk to each other. The staff is therefore very important in keeping the conversation between the patients flowing. When the staff is absent it's usually quiet. The staff has an important function in creating a sense of security when patients sit together.

One carer said that many patients seldom complained: “It's useful to know that he isn't the kind of person to complain, because then you know that if he has a problem he won't come to us with it. We have to pick it up for ourselves ...”

Acquaintanceship and everyday life in the nursing home

The patients were individuals, and their dementia disease made it more complicated to relate to each individual. One carer emphasized that this made the work challenging, but also interesting. Everything depended on the situation and the person. She said: “When you go into a room you can't follow a procedure, and say I am going to care for this patient in this way.” One manager highlighted a flexible approach: “It is achievable. It doesn't require more resources.”

Another manager described how a patient's life story was brought into the conversation during personal care of a patient:

> I myself experienced as a nurse, that when you are there during morning care, the patient has a carer with them, maybe three quarters of an hour, alone. You communicate and cooperate. You talk about the day today, what they have done earlier. It can be, not just personal care, but a pleasant experience.

One of the managers said that if a patient resisted care and they knew of problems in the patient's past they could arrange fixed, familiar carers.

A couple of managers said that they experienced varied recognition in the staff for the importance of connections to the patient's life: “Some of the staff are extremely interested and understand that the patient's restlessness can be related to things that have happened during the day, which are again related to the patient's own life.” Some carers said that they did not have time to reflect about a patient's earlier life.

A more challenging working day in the nursing home

Inadequate preparation

Preparing for the move was an important theme, particularly related to patients with dementia disease. Carers pointed out that they were poorly prepared when the patient moved in: “Those of us working here, struggling with all this, are just told that this or that patient is coming.” Carers would have liked to meet the patient at home, to have fixed carers to follow up the patient for the first few days, and to have the patient's room furnished with familiar furniture and possessions before the patient arrived. Collaboration with family members was emphasized. When the nursing home had a vacancy, a new patient was quickly moved in: “We don't always have time to tidy and clean the room so that it is ready for the next day, when it has been decided that the patient is coming.”

A tighter framework in the nursing home

All the managers and carers emphasized that patients' health when they came to the nursing home was at a lower level now than just a few years ago: “We treat them much more. Staffing levels have not increased correspondingly, so that the day to day work has changed.” One manager said that patients were so ill when they came to the nursing home that “nothing is more important than making it through the day, getting enough sleep and rest, peace and quiet, so that you survive until tomorrow...”

One manager said that it had been necessary to reduce staffing levels. They had to “get relatives in” and “use students” to a greater extent. There was no time to sit down and talk to the patients. One unit manager said that when the unit was very unsettled, they were allowed to increase staffing levels.

Substitutes and the need for nursing competence

Carers and managers said that the staffing level was manageable, but because of unfilled positions and illness, substitutes were often used. This could be challenging. Using the nursing home as an arena for language training lead to misunderstandings for both patients and carers. One carer said that she had more than once experienced that conflicts arose between untrained carers and patients. Carers thought that nurse training gave a good background to understand the challenges related to patients. One carer said: “If there's just one nurse at work, then you feel safe, you relax because you get help when you need it. But there are so many shifts without nurses.”

Discussion

The methods we have used shed light on carers' and managers' understanding of identity, continuity and identity-supportive care of patients with dementia disease in nursing homes.

This is related to person-centred nursing. Material from more nursing homes would probably give a broader understanding. The care of patients with dementia disease in all nursing homes takes place within the same framework, legislation and guidelines, and one can assume that the results are to a large extent applicable to other nursing homes, an assumption that is supported by the authors' experience. There will however be regional variations.

Challenging situations – supporting belonging

When patients were not interested in, or did not have the energy to take part in activities, this could be related to illness or weakness (cf. Falk, Wijk, Persson, & Falk, 2012). In order to help the patient carers must understand the development of dementia disease (e.g. Edberg, 2011). Patients with dementia disease remember to varying degrees what they have done earlier in their lives (Drageset et al., 2013, 2012). It can be demanding to attempt activities that were earlier enjoyable. If the patient remembers the activity they can be reminded of what has been lost. If the patient does not remember, the activity is no longer familiar, but new each time, and can be exhausting. The patient often moves between these extremes. Carers must use discretion (c.f. Martinsen, 2005) to distinguish between what the patient is capable of, what gives an experience of loss, and what the patient can achieve with help. They must find the time that suits the patient best. Cooperation with family members is important. With good help and support to use their resources and abilities, patients can take part in earlier activities and experience a continuity of identity.

Cipriani, Faig, Ayrer, Brown and Johnson (2006) found that activity level changed or decreased after moving to a nursing home, because of changes in both physical health and opportunities for activity. This can also be an expression for a natural positive withdrawal (c.f. Tornstam, 1997). “Engagement with life” (Rowe & Kahn, 1997) can include activity and contemplation of life. Erikson and Erikson (1997) show how hope, belief and wisdom are part

of the activities of old age. Personal care is a situation where identity can be reinforced by focusing on these values. Carers can talk about subjects that are connected to the patient's life story, without necessarily expecting answers. The carer can sing, listen to the radio or say an evening prayer if it is meaningful for the patient.

Carers and managers thought that restlessness or challenging behaviour could indicate unpleasant experiences in patients' lives. However if the patient does not understand what is happening, personal care can be experienced as an abuse. The perspective of the person with dementia disease must be taken into account (Cohen-Mansfield et al., 2006). Feelings are still meaningful even though people and incidents are forgotten (Magai, Cohen, Gomberg, Malatesta, & Culver, 1996). The carer must attempt to understand and relate to the patient's reactions together with the patient (c.f. McCormack, 2004; Antonovsky, 1987). Challenging behaviour increases if patients feel they are struggling to be understood (Brooker, 2003; Kitwood, 1997a, b).

Local familiarity and belonging

The participants in the study talked enthusiastically about their understanding of life story, belonging to a place, tradition, history and community. The sense of belonging and familiarity with people seemed consistent and central in the rural nursing home. Patients with dementia disease in nursing homes in northern Norway and their relatives have described a close relationship to nature (Drageset et al., 2013, 2012). Carers and managers describe how a feeling of community is also important for patients' sense of security.

A high degree of shared belonging and familiarity between managers, carers, patients and relatives will affect patients' feeling of being at home in the nursing home (c.f. Cooney, 2010; Zingmark, Norberg, & Sandman, 1995), and form an important foundation for care in the nursing home (Zingmark et al., 2002). Falk et al. (2012) have shown that routines and rituals are important aspects of feeling at home, expressing facets of the person's identity formed through lifelong social interaction. Moving to a nursing home involves greater or lesser changes in personal daily routines, and the adjustment is most demanding for patients with dementia disease. When managers and carers in the nursing home are aware of the connection between a patient's life story and the area's history and traditions they can affirm and support aspects of the patient's identity. Familiarity with local people and a sense of a local connection can give small rural nursing homes an advantage that should be taken into account in discussions about centralization of health services.

Home visits: Getting to know the patient

Managers in the urban area wished to get to know the patient before the move to the nursing home. If possible they would conduct a home visit, particularly with respect to patients with dementia disease, to collect some of the information the carers and managers in the rural area considered positive. Drageset et al. (2012) have shown that family members experienced the patient's move to a nursing home as a demanding transition (c.f. Lee, Simpson, & Froggatt, 2013). If carers in the nursing home get to know the patient and relatives before the move, it can make the transition easier to understand and deal with, so that the experience is as meaningful as possible for the patient. If one manages to establish a relationship of security and trust, the feeling may remain even if the patient does not remember the individual carers at the nursing home.

The patient with dementia disease who moves to a nursing home will require coordinating services from the health and care services (c.f. Helse- & omsorgsdepartementet, 2011, 2009), and the development of the patient's illness and needs are often known to the local health services before admission. It should therefore be possible to conduct a home visit and build a certain familiarity, also to patients without close relatives. The home a person lives in before the move to the nursing home can give information about the person's life. Establishing a supportive relationship in this challenging phase of the patient's life can help to maintain a sense of belonging.

Before the patient moves to the nursing home, carers on a home visit can work together with the patient and family members to document the patient's life story, and this can be the basis for professional reflection in the care group. Listening to the patient's and relatives' narratives is crucial to being able to support the patient's identity in the nursing home, and requires time and competence (Drageset et al., 2013, 2012; cf. Normann, Norberg, & Asplund, 2002).

Even though a home visit is prioritised before admission to the nursing home, it is not always feasible. The patient can be so ill that the admission must take place quickly. By inviting local inhabitants to events at the nursing home, they become acquainted with the building, staff and patients there.

A home visit requires competent staff if it is to function as intended. Carers and managers said that resources had been reduced, both directly and indirectly, since patient morbidity had increased without corresponding increases in staffing levels. Björnsdottir (2009) shows how New Public Management has contributed to a shift in focus in home based care, from ethical to financial considerations. The underlying values of nursing homes also appear to be

changing (c.f. Norsk Sykepleieforbund, 2011). National guidelines are essential to secure ethical practice locally (c.f. Helse– & omsorgsdepartementet, 2010, 2003, 1988).

Daily life – supporting belonging

There are large individual variations in how a patient's earlier activities, habits, interests and values are expressed in daily life in the nursing home (cf. Cohen-Mansfield et al., 2000). Participants highlighted everyday activities that everyone takes part in. Carers need to consider how personal care or a meal can be a positive experience for each patient.

One manager reported the possibility of creating a "pleasant experience" during personal care of a patient, by the conversation being guided towards something that is meaningful for the patient, as far as was appropriate for the situation. The aim was to contribute to the patient experiencing continuity, by reminding the patient of activities, interests and values that were important earlier in the patient's life. This also contributes to the patient's sense of belonging. Documentation and reflection in the care group allows carers who do not know the patient so well to also make use of this possibility.

Conversational topics around the table at mealtimes were often seasonally related. The annual cycle of nature had shaped the work and daily life of many of the patients (Drageset et al., 2013). Mealtimes in the nursing home give an opportunity to get to know patients better and strengthen relationships and identity. Interviews with patients with dementia disease in nursing homes show that they value traditional food (Drageset et al., 2013). The social activity of a shared meal, serving of traditional food and conversations about traditions and stories from the local area, will in themselves help to support a sense of identity and

belonging. People with knowledge of local history can be invited to talk about customs and practices from the local community, or one can read local literature. Religious services and songs can also give a sense of tradition and belonging. Many family members make a big effort for their relatives in the nursing home, and some would be interested in participating more in social activities in the nursing home (Drageset et al., 2012). Visiting family members should be invited to take part in mealtimes, or, for example, encouraged to read from the local paper.

For a group of patients with dementia disease to have a conversation usually requires the participation of competent carers. Brooker (2003) says that stress and confusion can be the result if carers do not have the competence to create a positive social environment for the patients. It is important to find a balance between confidentiality and an approach based on the individual's life.

Competence in nursing homes - supporting person-centred nursing

In this study carers and managers talked positively about care in nursing homes. This is not always the case (cf. Wadensten et al., 2009). Carers described managers as receptive and approachable. Managers ensured that carers had access to courses about dementia disease and relevant literature. This reflects a professional management in line with person-centred care in dementia disease (c.f. McCormack, 2004; Kitwood, 1995). Managers and nurses have the main responsibility to ensure that person centred-care does not become empty words (Brooker, 2003).

There appeared to be limited time for, and possibly recognition of, the importance of counselling of carers and managers involved in person-centred dementia disease care, and reflection on how a sense of belonging can be strengthened in patients with dementia disease. Skaalvik, Normann and Henriksen (2010) found that the learning of student nurses during placements in nursing homes was limited because of what was seen as the lack of a person-centred approach in the care of patients with dementia disease. Transferring attitudes and knowledge to practice can be challenging, and managerial and counselling competence needs to be strengthened (Helse- & omsorgsdepartementet, 2005-2006).

Carers said that they felt more secure when a nurse was at work, without explaining what they meant. It may be that the nurse's expertise gives carers security in their daily work. Language problems could prevent satisfactory nursing, and it was sometimes tiring to care for patients with dementia disease (c.f. Brodatry et al., 2003; Beck, 1996). Nurses need to have the opportunity to counsel carers with less expertise; particularly untrained staff, who need support if they are to take care of patients. Bolling, Pedersen and Førde (2009) show that managers and health professionals would like to have access to guidance and advice about ethical issues in nursing homes. Situational leadership is appropriate since people and situations vary, requiring an individual approach (Lynch, McCormack, & McCance, 2011). Managers must ensure that the carers are supported (cf. McCormack, 2004) and empowered (c.f. Caspar & O'Rourke, 2008), in order to be able to give the best care to the patient with dementia disease. This requires enough nurses, with sufficient time to meet the challenges that come, and with the ability recognise their own limits (c.f. Helse- & Omsorgsdepartementet, 1999).

Conclusion

Measures in the nursing home that promote a sense of belonging can reinforce a patient's identity. A home visit before the move to the nursing home is one such measure. By listening to the patient and their family, carers will get to know the individual and contribute to documentation and reflection in the care group. In daily situations, such as personal care and mealtimes, carers can deliberately use their actions and behaviour to support each patient's sense of identity. Positive attention is directed towards the patient's life, rather than focusing on challenging behaviour or restlessness. Differences in personality, background and dementia disease development, and ill health of patients in nursing homes make demands with respect to professional assessment and expertise.

The values and attitudes that carers and managers emphasize are often challenged in the nursing home. Time and systematic effort is needed to promote professional nursing values. It is especially important that untrained and substitute staff are given continual support and guidance.

There is a need for a more comprehensive investigation into how a patient's identity is expressed and can be affirmed during personal care and mealtimes. There is also a need for increased understanding of how nurses contribute to the care group, as well as the characteristics of management in nursing homes.

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Tables

Table 1 |Examples from the content analysis

Meaning unit	Condensed meaning unit	Code	Subtheme	Theme
It will be safe for relatives, because even though they may not know you or me, they always know one or five of the other carers who work here ..., have visited here or …, they know someone who has had a family member in the nursing home …, so that the patients …, or relatives know what they are going to meet.	There is a security for patients and relatives in knowing someone who works, has worked, or has some other connection to the nursing home.	Familiarity contributes to security and a sense of belonging	Personal acquaintanceship in small municipalities	Local personal acquaintance-ship and belonging
People who work here today have in fact cared for someone at home, and so when that person, a mother or a father (…) has died, they have applied for a job at the nursing home. Because they may have accompanied them here in the final phase and they have seen …, and wanted to work here.	Many of those working in the nursing home have previously had responsibility for care of a person in their own home. When the person they had cared for moved to the nursing home or died, they wished to work at the nursing home.	Personal experience of caring and familiarity motivates care in the nursing home.	Valuing competence.	Local personal acquaintance-ship and belonging

Table 2 Overview of themes and subthemes obtained by content analysis

Theme	Subtheme
Local personal acquaintanceship	Personal acquaintanceship in small municipalities
	Valuable competence
The patient's life story	Documenting the patient's life story
	Cooperation with family members in documenting the life story
The significance of the patient's earlier life in the nursing home	The patient's identity and development of dementia disease
	The significance of familiarity for calm, well-being and conversation
	Acquaintanceship and everyday life in the nursing home
A more challenging working day in the nursing home	Inadequate preparation
	A tighter framework in the nursing home
	Substitutes and the need for nursing competence