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Turning Toward the Inevitable: How Nursing Home Staff Manage Relatives' Expectations of Dementia Progression

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ABSTRACT

This article examines video recordings of care plan meetings between nursing home care staff and relatives of residents with dementia in Finland. Prominent in these meetings is the activity of updating relatives about a resident's condition. An associated practical task for the staff is to assist relatives in making sense of a resident's observed and reported deterioration. The staff employ *inevitability claims*, whereby they state that a resident's health will inevitably deteriorate further. This action normalizes deterioration by attributing it to dementia, and it enables the staff to account for a resident's present, observed deterioration and to guide relatives' expectations for the future. In doing so, the staff attend to epistemic considerations by avoiding claiming that relatives are unaware of the realities of dementia and, rather, invoking dementia as an already familiar reality. Data are in Finnish.

Dementia is a progressive illness caused by memory disorders, including Alzheimer's disease, vascular dementia, and Lewy body dementia. Dementia reduces a person's ability to think and remember, and it causes deterioration in functional abilities including mobility, communication, and swallowing, leading to full-time institutional care for many. In Finland—the national context of our study—around 85% of people in residential care have dementia, and with the aging of the population, dementia has become the third most common cause of death (Official Statistics of Finland, 2023).

Dementia increases the risk of stroke, heart attack, and infections (Alzheimer's Society, 2024a). Depending on the specific diagnosis and individual factors, life expectancy is two to 10 years, but some people survive for more than 20 years (Alzheimer's Society, 2024b; Rait et al., 2010). This variation makes prognosticating death difficult compared to such conditions as cancer, which may explain why transition to palliative care can arrive relatively late (Van Riet Paap et al., 2015). Older people living with dementia (PLWD) can face periods of "long dying" (Kellehear, 2007, p. 207) in which the impacts of dementia are difficult to tease apart from frailty brought about by aging. This can lead to the somewhat paradoxical consequence that people interacting with PLWD may not show awareness that they are on an end-of-life (EOL) trajectory (Thuné-Boyle et al., 2010).

In this article, we investigate some of the social-interactional reverberations of the complexities entailed in interpreting observed deterioration in PLWD in full-time residential care. We do so by examining meetings between relatives and nursing home care staff (henceforth, staff). For relatives, awareness of inevitable illness progression is arguably always in the background.

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However, on a day-to-day basis, it can be difficult for them to attribute observed deterioration—including a decreased ability to walk or communicate—to dementia, frailty associated with aging, or inadequate institutional care. Observed and reported deterioration can thus give rise to a search for explanations and, sometimes, to questions about quality of care. This happens in a broader context in which the care of older individuals is facing a crisis due to lack of resources and workforce (Finnish Institute for Health and Welfare, 2022). Mistrust and conflicts between staff and relatives are not uncommon (Paananen et al., 2024), and the number of formal complaints is on the rise (Kangasniemi et al., 2021).

Staff face practical problems of their own when interacting with relatives. In this article, we investigate how these emerge and are handled in care plan meetings recorded in six Finnish nursing homes.

The activity of updating in care plan meetings

Care plan meetings are institutionalized, formally planned occasions in which staff and relatives convene to discuss a resident's condition. Prominent in these meetings is the activity[1] of *updating*, which involves extended (i.e., multi-unit) informing turns by the staff focusing on the resident's health condition and care regime. To get a handle on the practical problems that participants face in this context, we build on previous research on an activity that presents commonalities and differences with that of updating: giving news.

Some previous studies have focused on rather momentous news deliveries in which healthcare professionals communicate new life-changing diagnoses (e.g., cancer), terminal prognoses, or worrying test results to patients or their representatives (Cortez et al., 2019; Lutfey & Maynard, 1998; Maynard, 2006; Maynard et al., 2016; Maynard & Frankel, 2006; Stivers & Timmermans, 2017). News deliveries are initiated in a context of epistemic imbalance (Heritage, 2012) in which the professionals hold a knowing (or K+) position *vis-à-vis* recipients (patients or their representatives), who hold an unknowing (or K–) position. Indeed, a practical goal of news delivery sequences is to bring recipients to a knowing position, thus aligning professionals' and patients' or their representatives' states of knowledge. A practical problem for professionals relates to the unpredictability of how recipients can react to the news (see Maynard & Frankel's [2006, p. 271] discussion about "flooding out"). Maynard (2003) observed that receiving news about such a diagnosis as cancer has the potential to dramatically alter a recipient's lifeworld (resulting in a "noetic crisis," that is, a fracture in how one makes sense of their everyday life; p. 11). The perspective display sequence is a method professionals use to attenuate the impact of the news by fitting their delivery to what a news-recipient already knows or suspects (Maynard & Frankel, 2006; Pino & Parry, 2019). The activity of *updating* presents commonalities and differences with news giving.

When delivering and receiving updates in care plan meetings, staff and relatives already share knowledge of the resident's life-limiting diagnosis (dementia). Mentions and invocations of the resident's diagnosis are thus not constituted as news. The meetings happen in the context of what we might term *open dementia awareness*, to adapt Glaser and Strauss's (1964) notion of "open death awareness." However, on a day-to-day basis, interested parties face the practical task of making sense of observed changes in a resident's health, and here epistemic imbalances arise. The staff have more access to the resident as they interact with them daily, and they can draw on professional inferential frameworks (Drew & Heritage, 1992) to interpret observed changes. These epistemic resources form the foundation of the staff's updates.

[1]We adopt Heritage and Sorjonen's (1994, p. 4) definition of activity as "the work that is achieved across a sequence or series of sequences as a unit of course of action . . . a relatively sustained topically coherent and/or goal-oriented course of action."

Relatives draw on their own independent, albeit less frequent, observation of the resident and interactions with them, as well as their prior knowledge of the resident based on their relational history, to comment on and raise questions about the resident's health and care regime. However, they lack continuous access to the resident and thus rely upon the staff for updates. They also have less access to professional inferential frameworks and thus rely on the staff to offer explanations for observed and reported changes in the resident's condition. In this context, the staff can face the practical task of assisting relatives in making sense of a resident's deterioration. We will show that this entails careful handling of epistemic relationships by avoiding claiming that relatives are ignorant of the realities of dementia, which could threaten their "positive face" (Brown & Levinson, 1987) as responsible next of kin, and by guiding them to use their knowledge of dementia to interpret the resident's condition.

Another task documented in the news delivery literature consists of reaching a shared evaluation of the news. In research on U.S. genetic consultations, Stivers and Timmermans (2017) observed that doctors and parents of children with disabilities balanced the delivery of bad news regarding test results with bright-side considerations. The authors proposed that participants thus worked toward a "bivalent equilibrium," in which "the news remains fundamentally bad ... but it has a silver lining" (Stivers & Timmermans, 2017, p. 405). We find that reaching a convergence in participants' evaluations—sometimes by carefully balancing "optimistic projections" (Jefferson, 1988) or "bright side" considerations (Holt, 1993) with anticipations of inevitable deterioration and progression toward the EOL—is central to the activity of *updating* in the care plan meetings. In this context, staff and relatives face the task of addressing the ambiguities inherent to a resident's deterioration. For the staff, this entails the associated practical problems of enabling relatives to make sense of a resident's deterioration while addressing actual or potential concerns about inadequate care, managing expectations about future illness progression, and showing sensitivity to the actual or potential emotional impact of engaging in discourse about a resident's deterioration.

The overarching task of handling ambiguity resonates with the findings of the only study of which we are aware that investigated the activity of updating a recipient about a relative's health status (Beach, 2001). Although in a very different context—phone calls between the relatives of a woman with terminal cancer—that study highlighted the management of ambiguity (e.g., in terms of the woman's life expectancy and implications for participants' future arrangements) as a key practical concern.

In this article, we investigate how nursing home care staff address practical problems entailed in updating relatives of PLWD. Specifically, we examine their use of a previously undocumented social action whereby they claim that a resident's condition will inevitably deteriorate because of dementia. We term this an *inevitability claim*. We will demonstrate that the staff position and design it to address competing demands entailed in assisting relatives in making sense of PLWDs' deterioration: conveying reassurance while avoiding instilling false hope, and fostering realistic expectations about the future without causing undue concerns.

We will show that the staff use inevitability claims to calibrate their updates about a resident's condition and to address concerns stated or implied by relatives' actions (including noticing, assessing, and asking about the resident's condition). Across these circumstances, inevitability claims perform the retrospective function of explaining observed and reported deterioration by invoking dementia, and the prospective function of guiding relatives' expectations about the future. They manage aspects of staff accountability by attributing changes to dementia and thus ruling out quality of care as a cause of deterioration.

Inevitability claims are further designed to reassure relatives by introducing an element of "rationality" (Maynard & Frankel, 2006) or "normality in an otherwise changed reality" (Bye, 1998, p. 12). That is, invoking dementia normalizes bodily, cognitive, and behavioral changes

that would otherwise be treated as abnormal in the "natural attitude of common-sense thought and action" (Heritage, 1984, p. 56). Inevitability claims work alongside reassurance that the best possible care is being and will be delivered, constituting any observed and anticipated deterioration (akin to Maynard & Frankel's, 2006, "symptom residue") as an inevitable, and thus uncontrollable, consequence of dementia.

We will further show that, when claiming that deterioration is inevitable, the staff are chiefly oriented to epistemic considerations by producing dementia as already familiar to relatives. Situating dementia in the "common ground" (Clark, 1996) works alongside displays of sensitivity toward relatives and bright-side considerations, effectively working toward an "equilibrium" (Stivers & Timmermans, 2017) of hope and anticipation of inevitable deterioration (on "hope work"; see Peräkylä, 1991).

Our study is the first to investigate the practical problems entailed in giving updates about a person's health status. We further advance the field of social-interactional studies of discussions about illness progression and EOL, which have so far overwhelmingly focused on specialist medical settings (Parry, 2024; Wu & Zhang, 2024), and have specifically neglected the context of long-term, full-time institutional care for PLWD.

Data and method

The first author collected the data from six Finnish nursing homes, including 13 video-recorded and two audio-recorded care plan meetings with the relatives of 15 residents (six female, nine male) with a diagnosed memory disorder (total running time: 14 hours). Seven were first meetings after a resident's transition to the home. The meetings typically started with the staff updating the relatives about the resident's health and care and service plan. Practical matters, such as clothing and financial issues, were typically handled next.

The meetings were recorded with a camera on a tripod and/or an audio recorder placed on a table. In each, one to two relatives and one to three staff were present. Only three residents were present. One took part in the conversation, whereas two did not display engagement, likely because of cognitive impairment. Altogether, 22 relatives (11 female, 11 male) and 21 staff members (19 female, two male) participated in the meetings.

The staff and relatives gave written consent for the use of the recordings in research and publication of pseudonymized transcripts. The residents' consent was obtained by proxy. The Ethical Committee of the University of Turku approved the study.

In Finnish nursing homes, residents usually have individual rooms, and there are communal areas for eating and socializing. However, the data was collected during the Covid-19 pandemic in 2020–2021, when there were restrictions on social gatherings. All participants wore face masks. Postponing care plan meetings was common, and for this reason the six participating nursing homes produced an uneven number of recordings (one to eight meetings per home).

In the transcripts, all names are pseudonyms. "Nu" with a number refers to nurses and "Ma" with a number to nursing home managers. All meetings were in Finnish. We transcribed iconic and deictic hand gestures, nods, and headshakes, and marked the onset of embodied actions with an asterisk. Our argument significantly hinges on our analysis of discourse markers that do not have a straightforward translation in English. We therefore marked translations as tentative through scare quotes (e.g., 'as we all know' for *-han* and *-hän*).

Our method is conversation analysis (Sacks, 1992; Sidnell & Stivers, 2014). Our investigation arose from an interest in discussions about illness progression and EOL in the meetings. These happened in five activity contexts: (a) when the staff updated relatives about a resident's condition and care plan; (b) when discussing associated practical matters (e.g., a need for additional clothing); (c) when recapitulating the update and asking about relatives' hopes and

concerns; (d) while agreeing on ways to contact relatives, including in emergencies; and (e) while checking the resident's documentation including care wills and do-not-resuscitate orders. We found that in the last two contexts, the staff primarily oriented to the practical accomplishment of administrative procedures. By contrast, in the first three contexts, the staff observably handled practical problems raised by the activity of updating relatives and its interactional *sequelae* (including discussions of associated practical matters and relatives' hopes and concerns), especially in terms of managing relatives' expectations for the resident's present and future health and care. We made this the focus of our subsequent analyses, in which we identified the social action we examine in the remainder of this article. Our empirical basis consists of 14 segments of interaction from eight meetings in which the staff claim that a resident's deterioration is inevitable.

Analysis

The staff produce inevitability claims in the context of updating relatives about a resident's condition and care plan (Extracts 1 and 4), when discussing associated practical matters such as the need for more clothes (Extract 3), and after recapitulating the update and asking relatives about their hopes and concerns (Extract 2). We will first examine the design of inevitability claims to then analyze the two sequential positions in which the staff use them: after a staff member's assessment of the resident's condition (N = 9), and after relatives' questions, noticings, and assessments about the resident's condition (N = 5).

The design of inevitability claims

Inevitability claims invoke future deterioration as unavoidable and frame this as a familiar reality, rather than news. In Finnish, information can be explicitly marked as familiar with phrases like *me kaikki tiedetään* ("we all know"; see example a, below), or by using discourse markers that treat the information as common, shared, or obvious. The most common in our data are the Finnish enclitic discourse particle *-han/-hän* ("as we all know"/"indeed"; examples b and f, below) and the modal particle *kyllä* ("indeed"/"sure", example c). Both mark a situation as belonging to common experience or general knowledge (Halonen, 1996; Hakulinen, 2001; Hakulinen et al., 2004, § 830, § 1717; Laitinen, 2002). They are often used to weigh the speaker's argument and preempt disagreement (Hakulinen, 2001; Niemi, 2010). Hence, they function as alignment tokens, corresponding roughly to the German modal particle *ja* and Swedish *ju*. They also share qualities with the English *you know* (Clayman & Raymond, 2021). However, in Finnish there is also a closer equivalent to *you know*, the fixed expression *tiedätkö* ("do you know"), which invites the recipient to recognize the speaker's experience and display agreement (Suomalainen, 2020). The main difference with *tiedätkö* is that *-han/-hän* and *kyllä* highlight factual knowledge rather than personal experiences. They can also be combined as *kyllähän* ("as we all know"/"sure"; example d), which amplifies the obviousness of the described reality.

Obviousness can also be conveyed through discourse markers such as *tietysti* ("naturally"/"of course"; example a), *totta kai* ("certainly"/"of course"; example e), and *tosiaan* ("indeed"/"truly"; example f). In example e, *totta kai sitä heikkenee* ("of course one gets weaker"), the particle *sitä* also conveys that the speaker has relevant personal experience (Hakulinen, 1975), specifically, professional experience of taking care of people with dementia.

```
a) ja sitte: tietysti me kaikki tiedetään et sit  jossain vaiheessa
   and then of course 1PL all know.PASS PCL then somewhere phase.INESS
   and the:n of course we all know that at some point,

   niin, sairaus (.) vie     sit  loppuun.
   PCL   illness    take.3SG then end.ILL
   the illness (.) will take one to the end.

b) mut kuntouttamaanhan        me ei       enää    pystytä        et,
   but rehabiltate.INF.ILL.CLT we NEG.PASS anymore be.able-CONNEG PCL
   but 'indeed' we cannot rehabilitate anymore so,

c) ihan sairauden  myötä kyllä (.) hänel  menee   pikkuhiljaa
   just illness.gen ptc  ptc       3SG.ADE  go.3SG  gradually
   just with the disease 'indeed' (.) she will gradually lose

   just    nää    käveleminen ja  kyvyt      mitä on     jäljellä,
   exactly DEM.PL walking     and ability.PL what be.3SG left
   exactly these walking and the abilities that are left,

d) kyllähän se  sit pikkuhiljaa tekee  tehtävänsä    et ei
   PTC.CLT  DEM then gradually  do.3SG task.GEN.POSS PCL NEG.3SG
  'as we all know' it ((the disease)) will gradually do its job so

   sitä-   sitä    painoo     sit kauheesti, päinvastoin se
   DEM.PTV DEM.PTV weight.PTV then terribly  conversely   DEM
   one will not really gain weight, on the contrary the weight will

   rupee     pikkuhiljaa siit putoamaan,
   begin.3SG gradually   ADV  drop.INF.ILL
   begin to come down little by little,

e) totta kai sitä    heikkenee  pitkäs     juoksus,
   of course PCL    weaken.3SG long.INESS run.INESS
   of course one gets weaker in the long run,

f) mut näinhän se  tosiaan muistisairaal              niin menee.
   but ADV-CLT DEM indeed person.with.dementia.ADESS PCL  go.3SG
   but 'as we all know' this is indeed how it goes for a person
   with dementia.
```

Treating knowledge about future deterioration as familiar contrasts with framing it as news, which would invite recipients to display the newsworthiness of what is being told and to assess it (Maynard, 2003). Indeed, relatives respond to the staff's inevitability claims with acknowledgment and agreement tokens. Marking future deterioration as a familiar reality achieves several interactional outcomes. It displays consistency with the context of institutional care for PLWD in which progressive deterioration "is the new normal."[2] By marking deterioration as familiar, the staff also avoid being heard as claiming that relatives are disregarding the reality of dementia, which protects their "positive face" as responsible next of kin (Brown & Levinson, 1987). Finally, cueing relatives not to treat what is being said as news arguably softens the possible emotional uptake of the inevitability claim (see Maynard & Frankel, 2006, p. 271).

We will also show that framing deterioration as familiar works alongside other practices designed to soften the impact of inevitability claims. For example, the staff do not directly refer to the individual resident but, rather, refer to dementia, to people with dementia as a category, and to the body. They also use zero-person constructions (which we tentatively translate with the English impersonal

[2]We thank an anonymous reviewer for this observation.

pronoun "one") or omit a reference entirely. These practices embody sensitivity toward poor carepoor care relatives by avoiding overtly stating that the resident will experience inevitable deterioration, and rather making this understanding available by implication (cf., Ekberg et al., 2019; Land et al., 2019). Concurrently, treating the resident's situation an instantiation of general patterns of dementia progression contributes to endowing the claim with a sense of objectivity and inevitability.

Sequential positions and functions of inevitability claims

The staff use inevitability claims to address practical problems raised by updating relatives about a resident's condition in two sequential contexts. First, following staff members' own assessments of the resident's condition, inevitability claims calibrate those assessments by managing possible implications that relatives could draw from them, such as the possibility that the course of the resident's condition is unpredictable (Extract 1) or that it could improve or remain stable (Extract 2). Here, inevitability claims manage the staff's professional accountability and direct relatives' expectations by normalizing deterioration.

Second, following relatives' actions—including assessments, noticings, and questions about the resident's condition (Extracts 3 and 4)—inevitability claims manage assumptions embodied in those actions, such as the possibility that the resident's deterioration could be caused by care he or she did not receive or that their condition could improve or remain stable. Here too, inevitability claims manage the staff's professional accountability and direct relatives' possible expectations by normalizing deterioration.

Calibrating the staff's assessments of the resident's condition

Extract 1 is from the first care plan meeting following a resident's transition to the home. It takes place in a dining room. The resident's wife, Eva, and three nurses (Nu4, Nu5, and Nu6), are seated around a table. Konsta, the resident, is not present, and there are no other people in the room. The nurses have informed Eva that Konsta's medication has been changed to manage aggressive behavior, and that Konsta now needs a wheelchair to move about (data not shown). In Extract 1, the nurses report Konsta's occasional problems with swallowing. We will focus on the use of an inevitability claim from line 19.

Extract 1. (Meeting 4; Nursing home 3; Eva = resident's wife; Nu4, Nu5, Nu6 = nurses, starting at 8:53)

```
01 Nu4: Ja hänellähän on koitettu sit sitä sakeuttamisainetta?
        And we have 'as we know' tried giving him that thickening
        agent?

02      *(1.0)
        * EVA AND NU5 NOD

03 Nu4  ja se tietysti sit koska tietysti *kaikki niinku nestemäinen
        and that is of course because naturally *all erm liquids
                                  *MOVES HAND BACK AND FORTH IN FRONT OF MOUTH
04 Eva: Mm m?=
        Mm m?=

05 Nu4: =niin viel enemmän *se on se aspirointivaara,
        =cause even higher *risk of aspiration,
                           *TOUCHES CHEST
```

```
06        Mut ei hän sitäkään kyl aina tarvi. [*Se on niinku jotenkin-]
          But he does not always need that either. [*It is somehow-   ]
                                               *SPREADS HANDS

07 Nu5:                                        [Niin ei,  Ei,  Niin.   ]
                                               [Yeah no,  No,  Yeah.   ]

08 Eva: [Nii, mm. ]
        [Yeah, mm.]

09 Nu5: [*Nii  hän] ei [niinku ] osaa niellä,=
        [*Yeah he ]    [kind of] cannot swallow,=
        *TOUCHES FACE MASK WHERE THE MOUTH IS

10 Nu4:                [Mm.    ]
                       [Mm.    ]

11 Nu4: =Joo,
        =Yeah,

12 Nu5: Ja sit joskus *hän osaa niinku niellä mehuukin ihan
        And sometimes *he can swallow even juice just fine
                      *TOUCHES FACE MASK WHERE THE MOUTH IS

13      [et kun on semmonen päivä.      ]
        [when he has that kind of a day.]

14 Nu4: [Nii,   *Juu juu.    Juu,       ]
        [Yeah,  *Yeah yeah.    Yeah     ]
                *NODS REPEATEDLY

15 Eva: [Nii just. *hhh    ]
        [Right.    *hhh    ]
                   *BREATHES OUTWARDS, THEN TILTS HEAD BACK

16 Nu4: [Juu,   Juu.    ]
        [Yeah,  Yeah.   ]

17 Nu5: *Se on ihan-, *Se on niin arvotus.
        *It is quite- *It is such a mystery.
        *SHAKES HEAD  *SHAKES HEAD

18 Eva: [Mm.]
        [Mm.]

19 Nu4: [Se ]  on     kyl ihan totta. Mut näinhän se tosiaan
        DEM   be.3SG  pct quite true  but ADV-CLT DEM indeed
        It is quite true. But 'as we all know' this is indeed how it

20      muistisairaal              ni (.)  *menee. Päivät voi  olla
        person.with.dementia.ADESS PCL     go.3SG day.PL can.3SG be
        goes for a person with a memory disorder. Days can be
                                           *EVA AND NU5 NOD

21      ihan erilaisii,*      et et, (1.0) *Et se  on- Niinku se on
        quite different.PL.PTV PCL PCL  PCL DEM be.3SG PCL DEM be.3SG
        quite different,* like, (1.0) *It is- It is erm
                        *NU5 NODS     *EVA NODS
```

22 **jotenkin aattelee niinkun öö vaikea, vaikea sairaus**
somehow think.3SG PCL PCL difficult difficult disease
one somehow thinks it is erm a difficult, difficult disease

23 mitä ei välttämät niinku osaa (.) ihan hoitajakaan aina*
*that one cannot necessarily (.) even as a nurse always **
*EVA NODS

24 [sil- sillai ymmärtää tai] ennakoida vaiks kuin paljon
[*understand li- like that or*] *predict no matter how much*

25 Eva: [Niin just. Se on- .hhh]
[*Right. It is- .hhh*]

26 Nu4: ois tehny, erilaisten [*niinku] potilaitten kanssa?
one has done, with different [**kinds of*] *patients?*
*NU6 NODS

27 Eva: [Mm.]
[Mm.]

28 Nu4: Mut mut, etenevä ↑sairaus, et,*
*But but, a progressive ↑disease, so,**
*EVA AND NU5 NOD

29 Nu5: [Mm,]

30 Nu6: [Mm,]

31 Nu4: Sillai et täytyy jotenkin- vaiks kuulostaa- kuulostaa kurjalt
So one has to somehow- even though it sounds- sounds sad

32 mut niinku m, *et eteenpäin jatkuvasti [mennään] et koitetaan
but PCL PCL forward all.the.time go.PASS PCL try.PASS
*but like m, *we are going forward all* [*the time*] *so let's try and*
*MOVES HAND GRADUALLY TO THE RIGHT

33 Eva: [*Niinpä.]
*[*Indeed.]*
*NODS

34 Nu4: ylläpitää sitä toimintakykyy (.) mikä siel *edelleen on,
*maintain that functional ability (.) that there *still is,*
*EVA NODS

35 [**Mut**] **kuntouttamaanhan me ei enää pystytä**
but rehabiltate.INF.ILL.CLT we NEG.PASS anymore be.able-CONNEG
[***But***] ***we cannot rehabilitate 'as we all know' anymore***

36 Nu5: [↑Mm,]
[↑Mm,]

37 Nu4: *Et, (1.0) Et et, But kaikki *oman- *mitä niinku (.) oman,
**So, (1.0) So so, But everything *that we can with (.) our-*
*NU6 NODS *NU5 NODS *NU4 NODS

38 oman voimavarojen *ja semmosten (.) *kautta niin,
*through our own resources *and such (.) *do then,*
*NU6 NODS *EVA NODS

```
39      tehdään kyllä kaikki,        *
        we will of course do everything,*
                                     *NU6 AND EVA NOD
```

Nurse 4 reports on the use of a thickening agent to prevent liquid aspiration but mitigates this news by describing Konsta's swallowing problems as occasional (lines 01, 03, and 05–06). After confirming this (line 07), and in overlap with Eva's acknowledgment (line 08), Nurse 5 elaborates on the occasionality of Konsta's swallowing problems (lines 09 and 12–13), which Nurse 4 further supports (lines 11, 14, and 16). Eva responds with *nii just* ("right"; line 15), which conveys understanding in the sense of recognizing the logic of what Nurse 5 is saying (Sorjonen, 2001, pp. 132–133). At the end of her turn, Eva produces an outbreath and tilts her head back slightly (line 15), which can be interpreted as a sigh of relief in response to the more positive reporting in line 12. We are unable to offer a definitive analysis of Eva's gesture because she wears a face mask.

Nurse 5 further characterizes Konsta's swallowing problems as unpredictable and inexplicable with the idiomatic assessment "it is such a mystery" while shaking her head as a display of wonder (line 17). Using an idiom can propose topic termination and a shift to other matters (Drew & Holt, 1988). We propose that Nurse 5's rendition of Konsta's condition as unpredictable and inexplicable raises two possible practical problems for the staff. The first is a problem of professional accountability insofar as Nurse 5's assessment can be taken to imply that the staff do not have sufficient understanding of Konsta's condition, threatening their "positive face" as competent professional caregivers (Brown & Levinson, 1987). Second, by framing Konsta's ability to swallow as unpredictable, Nurse 5's report can be taken to imply that bad and good days are equally likely (see lines 09 and 12–13). If left unchallenged, this could support the expectation that Konsta's overall condition will remain stable. Nurse 4 uses an inevitability claim (from line 19) to manage both problems.

Nurse 4 first agrees with Nurse 5's assessment ("it is quite true"; line 19), then distances herself from it (note the contrastive *mut* "but" in line 19)—thus mobilizing an "agreement + disagreement" turn format recurrently found in dispreferred, disaffiliative responses (Schegloff, 2007, pp. 69–70). By attributing Konsta's swallowing problem to dementia (referred to as a "memory disorder"; lines 19–20), Nurse 4 ostensibly manages one of the implications of Nurse 5's characterization of it as a "mystery": that the staff do not have insights into it. She marks this information as familiar through *-hän* ("as we all know") and *tosiaan* ("indeed"; line 19). Referring to "a person with a memory disorder" (line 20) further embodies the assumption that everyone is familiar with Konsta's diagnosis, including Eva. Treating knowledge about future deterioration as common ground minimizes the disaffiliative and corrective quality of Nurse 4's action relative to Nurse 5's previous characterization. Building the claim as a generalization about people with dementia (lines 19–20) grants the claim epistemic force by evoking epidemiological knowledge. Eva displays recognition with a nod (line 20), thus validating Nurse 4's treatment of Konsta's dementia as a familiar reality.

Nurse 4 further addresses Nurse 5's characterization of Konsta's condition as unpredictable. She initially supports the notion that Konsta's swallowing problems cannot be predicted on a day-to-day basis. She even articulates this problem in more explicit and detailed terms than Nurse 5 had done (lines 20–24 and 26). Eva displays understanding with a nod (line 23) and *niin just* ("right"; line 25) in recognitional overlap (Jefferson, 1984). Eva appears to be about to elaborate her affiliation, possibly by proffering a completion of Nurse 4's projectable articulation of the difficulty of predicting Konsta's condition (*se on-* "it is-,"; line 25). She nevertheless cuts out as Nurse 4 continues talking. Nurse 4 then alludes to inevitable future deterioration ("but a progressive disease so"; line 28), thus conveying that the *overall* future trajectory of Konsta's condition is known. This challenges the absolute unpredictability implied by Nurse 5's characterization, and thus manages the possible expectation that Konsta's condition remain stable.

Nurse 4 displays sensitivity toward Eva by stopping short of explicitly pointing out a future of inevitable deterioration. She abandons a projectable upshot ("So one has to somehow-"; line 31) in favor of the parenthetical empathic remark "it sounds sad," and the use of another allusion, which points to the inevitability of deterioration (*eteenpäin jatkuvasti mennään* "we are going forward all the time"[3]; line 32), reinforced by the use of an iconic hand movement, depicting the progression of Konsta's anticipated deterioration. She also avoids referring to Konsta directly. Eva affiliates with Nurse 4's position regarding the inevitability of future deterioration (line 33). With "indeed," she supports Nurse 4's treatment of this reality as already known.

Through her extended turn, Nurse 4 manages professional accountability. When addressing unpredictability, Nurse 4 alludes to the staff's experience of having supported patients with dementia (lines 23–26). Characterizing the overall course of Konsta's deterioration as predictable (line 28) protects the staff from the implication that they might not have insight into his condition. Nurse 4 also preempts the inference that physical deterioration could be attributed to inadequate care through the specification that the staff will work to "maintain that functional ability" (line 34) but "cannot rehabilitate" (line 35). This conveys commitment to delivering the best possible care and again locates the cause of deterioration in the progressive nature of dementia, construed as outside the staff's control. Producing this specification as common knowledge with *-han* (line 35) imbues it with a sense of taken for granted, intersubjectively sustained reality.

Nurse 4 further states the staff's commitment to delivering the best possible care (lines 37–39). This resembles the practice, observed in a hospice setting, of shifting the focus to controllable and reassuring matters as a way of moving out of discussions about future deterioration and EOL (Anderson et al., 2021). Extract 1 exemplifies how the staff use several calibrations when reporting on a resident's condition. After claiming the inevitability of deterioration to calibrate Nurse 5's assessment (lines 28 and 31–32), Nurse 4 adjusts the negative implications of the inevitability claim by describing what the staff will do to maintain Konsta's functional abilities (lines 32 and 34). She then calibrates this promise with a claim that rehabilitation is not possible (line 35), followed by yet another shift to promissory considerations (lines 37–39). The nurse can thus be seen to manage the competing demands entailed in reporting on a resident's condition: fostering realistic expectations without causing undue concerns, and conveying reassurance while avoiding instilling false hope.

In this context, inevitability claims manage the staff's accountability by excluding that the PLWD's deterioration is caused by inadequate care. They normalize the resident's problems, including Konsta's inability to control swallowing, by producing them as inevitable consequences of dementia. Framing deterioration as shared knowledge protects the relative's face by avoiding suggesting that they are unfamiliar with the resident's diagnosis while guiding them to use what they already know to manage their expectations for the future.

Extract 2 demonstrates that inevitability claims can be used to invoke not only the progressive nature of dementia but also its terminal nature. The resident's wife, Ada, the nursing home manager (Ma1), and two nurses (Nu1 and Nu7) are seated in a semicircle in a meeting room. Matias, the resident, is not present. This is the second care plan meeting (they had previously met a year before, when Matias moved into the nursing home). The meeting has already lasted over an hour; after going through Matias's care plan, the participants have started to discuss Ada's thoughts and hopes for the future. Ada told the staff that some friends had warned her about "horrible things" that will come as her husband's dementia progresses. Ada also said that she is worried about the future (data not shown). In Extract 2, the manager works to reassure Ada (lines 1–2, 4–8, and 10–11). We focus on how she uses an inevitability claim to calibrate her own assessment of Matias's condition from line 15.

[3]In spoken Finnish, the passive verb form is used instead of the first person plural: *me mennään* ("we are going"). Here, the pronoun *me* ("we") is missing, but translating this in another way would be problematic.

Extract 2. (Meeting 15; Nursing Home 2; Ada = resident's wife; Ma1 = manager; Nu1, Nu7 = nurses, starting at 74:54)

```
01 Ma1: Niinku se ↑hyvä tämmösessä ku ollaan niinku
        Erm the ↑good side in this is that in here we are a

02      hoito (.) yhteisössä?=
        care (.) community?=

03 Ada: =Nii.
        =Yes.

04 Ma1: Et meit on monta. *Et me voidaan niinku jakaa tätä *sun kans
        There are many of us. *So we can share this with   *you
                          *NU1 AND NU7 NOD                  *POINTS AT ADA

05      *ja sä voit niinkun meiänki kans keskustella ja jakaa sitä
        *and you can discuss with us and share that
        *MOVES HAND BACK AND FORTH TOWARDS ADA

06      asiaa ja totta kai  *omien läheistes kanssa ja se et me ainaki
        thing and of course *with your own close ones and at least we
                            *POINTS TO ADA'S LEFT SIDE

07      voidaan kertoo miten *meiän näkökulmast tässä menee ja
        can say how from *our perspective things are going and
                         *NU7 NODS

08      jos jotain me voidaan niinkun    [valottaa,     ]
        if there is something we can erm [shed light on,]

09 Nu7:                                  [*Mm.  Joo,    ]
                                         [*Mm.  Yeah,   ]
                                          *NODS

10 Ma1: Eli sitä todennäköisyyttä että mitä niinku tapahtuu.
        I mean the probability of erm what is going to happen.

11      Niin aina (.) me voidaan ↑sitä   *sitte *keskustella ja kertoa
        So always (.) we can discuss ↑it *then and tell you
                                         *NODS REPEATEDLY
                                         *ADA NODS

12      ja, ja tota: se että, (1.0) Et ku jotenkin aattelis- Et aina
        and, and e:rm so, (1.0) I mean somehow one would think- Always

13      toivoo vaa että niinkun täs rauhallisesti sais ↑nyt *mennä.
        one just hopes that one can peacefully keep going ↑now.
                                                         *NU1 NODS

14      Tällai niinkun nyt on näitä *hyviä- tämmösii tasasii hyvii
        As there are now these      *good- this kind of stable good
                                    *MOVES HAND HORIZONTALLY TO THE RIGHT
```

15 vaiheita. **Ja sitte: tietysti me kaikki tiedetään et**
and then of course 1PL all know.PASS PCL
phases. ***And the:n of course we all know that***

16 **sit jossain vaiheessa niin, sairaus (.) vie sit loppuun.**=
then somewhere phase.INESS PCL illness take.3SG then end.ILL
at some point, the illness (.) will take to the end.=

17 Ada: =Joo, [joo,]
=Yeah,[yeah,]

18 Ma1: **[Elämän,]** mutta että ↑sekin menee ihan- useimmiten
[Of life,] *but even that goes quite- most often*

19 hyvin kauniisti. =*
*very beautifully.=**
*NU1 AND NU7 NOD

20 Nu7: =Mm,=
=Mm,=

21 Ma1: =Siis sillä tavalla että se *ei- *siinä ei tuu sellasia-
*=Like so that it is *not- there are not that kind of-*
*SHAKES HEAD
*ADA NODS

22 .hh Koska tää- tämä ei oo sellanen joka aiheuttaa
.hh Because this- this is not something that causes

23 *sietämättömiä kipuja tai muita niinku vaikka syöpäsairaudet.=
**unbearable pain or other things like for example cancers do.=*
*NU1 AND NU7 NOD REPEATEDLY

24 Ada: =Nii. °Joo,°
=Yeah. °Yeah,°

25 Ma1: Että täs on niinku, tää on semmosta sit ↑hiljaista
So this is like, this is sort of ↑quiet

26 *hiipumista ja [rauhallista] *jotenki sinne-
**waning and [peaceful] *somehow in there-*
*NU1 NODS *MOVES HAND HORIZONTALLY TO THE RIGHT IN GRADUAL MOTION

27 Ada: [°Mm.°]
[°Mm.°]

28 Ada: Joo. Sit [kaikki pettää pikkuhiljaa,]
Yeah. Then [everything fails little by little,]

29 Ma1: [nukahdetaan sitte.]
[one will fall asleep then.]

30 Ma1: Niin. *Sillai vähitellen.
*Yes. *In a slow fashion.*
*NU1 NODS

The manager uses a bright-side formulation (framed as such through "the good side is"; line 01). She characterizes the nursing home as a supportive environment ("care community"; line 02) and further offers the staff's availability to discuss Ada's concerns and answer questions about the course of Matias's dementia (lines 04–08 and 10). She retains the allusiveness of Ada's prior talk by stopping short of mentioning illness progression and EOL (referring to *tätä* "this" in line 04; *sitä asiaa* "that thing" in lines 5–6; and *mitä niinku tapahtuu* "what is going to happen" in line 10).

The manager continues by evoking the possibility (framed as a "hope") that Matias will retain a good quality of life moving forward (rendered with "peacefully"; lines 12–13). She supports such optimism by mentioning that Matias's condition is showing "stable good phases" (lines 14–15). These descriptions concurrently limit the extent of optimism. "Hope" implies that less positive developments are possible. Referring to "stable phases" alludes to the inevitability of eventual deterioration (see Drew, 1992, on the "maximal property" of descriptions). Despite this, the manager goes on to calibrate the conveyed optimism with an inevitability claim, thus managing the possible inference, which could be drawn from her reassurances, that Matias remain stable in the future.

The manager's inevitability claim invites Ada to situate the previous hopeful projections in the context of the progressive and terminal nature of dementia ("the illness will take to the end"; lines 15–16). Future deterioration is produced as familiar (*tietysti me kaikki tiedetään* "of course we all know"; line 15). Consistent with this, the manager refers to Matias's condition as "the illness" (line 16), which embodies the assumption that Ada already knows its nature. Ada responds with tokens of agreement (line 17), which validate the proposal that she is familiar with Matias's condition. Producing future deterioration as familiar contributes to construing it as a factual and uncontestable reality. This has implications in terms of professional accountability because quality of care is implicitly excluded as a cause of deterioration. It further protects Ada's "positive face" by avoiding suggesting that she is unfamiliar with the realities of dementia.

In a pattern that recurs in our data, the inevitability claim, which the manager introduced to calibrate a bright-side formulation, is also calibrated through yet another shift to the designedly reassuring remark that, in most cases, people with dementia experience a good death (conveyed through *hyvin kauniisti* "very beautifully"; line 19; see also the contrastive *mutta* "but"; line 18). The manager grounds this optimistic projection in Matias's diagnosis (again, not named and only referred to as *tämä* "this"; line 22), which she contrasts to cancer (lines 22–23). The manager can thus be seen to carefully manage the balance between informing Ada about future possibilities without causing undue concern, and reassuring her without instilling false hope.

Responding to relatives' actions implying expectations

The staff also use inevitability claims to respond to relatives' assessments, noticings, and questions about the resident's condition. These inevitability claims cautiously correct or adjust assumptions, embodied in those relatives' actions, that the resident's condition could improve or remain stable, and that deterioration could be caused by inadequate care. Therefore, these inevitability claims, like those examined in the previous section, manage the relatives' expectations alongside matters of professional accountability by normalizing deterioration.

Extract 3, is from the same meeting as Extract 2 but about 13 minutes earlier. The participants have finished discussing Matias's current care and moved on to talk about his clothing. Nurse 7 has asked Ada to bring more T-shirts for Matias (data not shown). At the beginning of Extract 3, Ada builds on the topic of clothing by mentioning that Matias has recently worn jeans (line 01). In an emerging silence (line 02), she visibly raises her eyebrows, conveying that there was something unexpected about it. Nurse 7 confirms that the staff had put jeans on Matias that day (line 03). Ada then reports noticing that Matias has become significantly thinner (line 04), which the manager and the nurses confirm (lines 06–08). We focus on the manager's use of an inevitability claim from line 12.

Extract 3. (Meeting 15; Nursing Home 2; Ada = resident's wife; Ma1 = manager; Nu1, Nu7 = nurses, starting at 62:33)

```
01 Ada: nyt hänel oli lauantaina ↑farkut jalas.
        he wore ↑jeans just now on Saturday.

02      *(1.0)
        *ADA RAISES EYEBROWS

03 Nu7: juu,  [laitettiin.    ]
        yeah, [we put them on.]

04 Ada:       [mä huomasin    ] et oli kovin tyhjää farkut sisältä
              [I noticed      ] that the jeans were quite empty from

05      ku          [mä hänt] sen verran hieroin mut kyl hän-
        inside when [I      ] massaged him a bit but he sure has-

06 Ma1:             [*↓niin.]
                    [*↓yeah.]
                     *TILTS HEAD

07 Nu7:             [↑niin. ]
                    [↑yeah. ]

08 Nu1:             [ niin. ]
                    [ yeah. ]

09 Ada: >siis ei hän niin laiha oo *koskaan ollu kun nyt
        >I mean he has *never been as thin as he is now.
                                   *SHAKES HEAD

10      ku mä katoin< *kun ne sääretki on vähän *[niinku jo ranteet,]=
        I saw that *the shins too were almost   *like wrists already,=
                   *POINTS AT HER SHIN          *TOUCHES HER WRIST

11 Nu1:                                          [mm.   *◦.joo,◦      ]
                                                 [mm.   *◦.yeah,◦     ]
                                                        *NODS

12 Ma1: =ja  se  on     tietysti  koko ajan    sit  se  että kun
        and DEM be.3SG  of course all the time then DEM pcl when
        =and it is of course always the thing when

13      liikkuminen ja se   kropan      [käyttöhän   ] [vähenee    ]
        moving      and DEM body.GEN     use.CLT        diminish.3SG
        exercising and using one's body ['as we know'] [diminishes]

14 Nu7:                                 [*niin.      ]
                                        [*yeah.      ]
                                         *NODS

15 Nu1:                                                [*niin,    ]
                                                       [*yeah,    ]
                                                        *NODS
```

```
16 Ma1: [koko ajan.   ]
        [all the time.]

17 Ada: [mm,    joo.   ]
        [mm,    yeah.  ]

18 Ma1: et   * [lihakset]han niinku          [väistämättä] [kutistuu] ja
        PCL    muscle.PL.CLT PCL             inevitably    shrink.3SG and
        that* [muscles ] 'indeed' will erm [inevitably ] [shrink ] and
            *GESTURES "NARROW":  TOUCHES THUMBS WITH INDEX FINGERS

19 Ada:       [.joo,    ]                                  [.joo,    ]
              [.yeah,   ]                                  [yeah,    ]

20 Nu1:                                    [*on.          ]
                                           [*they are     ]
                                            *NODS

21 Nu7:                                                    [      mm.]
                                                           [      mm.]

22 Ma1: *ja surkastuu.  että se on     niinkun, se  on     sitä
        and wither.3SG PCL DEM be.3SG PCL      DEM be.3SG DEM.PTV
        *and wither.    so it is erm, it is part of the
        *NU1 NODS

23      surullista semmosta.   *(.) joo. että mille    ei       oikein
        sad.PTV that.kind.of.PTV    yeah  PCL to which NEG.3SG  really
        sad quality ((of it)). *(.) yeah. to which one cannot really
                               *NODS

24      (.) [kauheasti] voi   sitte.
            terribly  can.3SG then
        (.) [do much   ] then.

25 Nu1:     [*mm.  ei,]
            [*mm.  ei,]
             *NODS

26 Ada: joo e:i, se on ihan ymmärrettävää. joo,
        yeah no:, it is quite understandable, yeah.

27 Ma1: et siihen me (.) vaan ↑eläydymme sitte.
        so with that we (.) simply  ↑live with then.
```

Ada's reported noticings can be heard as complaint-implicative (see Schegloff, 1988, on how "negative observations" can implement complaining). She uses an extreme case formulation, a practice commonly found in complaints (Pomerantz, 1986), to observe that Matias "has never been as thin as he is now" (line 09). The complainability of Matias's weight loss is further conveyed through the graphic detailing in line 10. The manager displays an orientation to such complainability in her response, which manages professional accountability and the expectation, implied by Ada's remarks, that Matias's weight remain stable.

After Nurse 1 confirms Ada's description (line 11), the manager claims that deterioration is inevitable (from line 12). She prefaces it with *ja* ("and"; line 12), which minimizes its corrective and disaffiliative import. She attributes Matias's weight loss to reduced mobility caused by dementia (lines 12–13 and 16),

which excludes other possible causes, including inadequate care, by implication. She produces weight loss as inevitable through "always" (line 12). The inevitability claim further constitutes dementia and its consequences as a familiar reality by marking them as obvious (*tietysti* "of course"; line 12), known to the participants (*kropan käyttö**hän** vähenee* "using one's body **'as we know'** diminishes"; line 13), inevitable (*koko ajan* "all the time"; line 16), and certain (*lihakset**han** niinku **väistämättä** kutistuu* "muscles will **indeed** erm inevitably shrink"; line 18). Omitting an explicit reference to dementia as the cause of reduced mobility (lines 12–13), and rather evoking it by implication, also contributes to treating it as an already familiar and uncontestable reality.

As Ada acknowledges (line 17), the manager shifts to the future tense (lines 18 and 22), stating that Matias's condition will deteriorate further. With this, the manager moves from normalizing weight loss to adjusting the conveyed expectation that Matias's weight remain stable in the future. She displays sensitivity toward Ada by empathically framing deterioration as a "sad" reality (lines 22–23). The manager's account has thus far protected the staff from attributions of responsibility implicitly, by attributing deterioration to dementia. She nevertheless goes on to explicitly frame deterioration as beyond the staff's control (lines 23–24). Having previously acknowledged the manager's inevitability claim (lines 17 and 19), Ada affiliates with the manager's statement about the uncontrollability of dementia by proposing that "it is quite understandable" (line 26). She thus averts the interpretation that she is complaining or blaming the staff. The manager proposes that the only available course of action is to accept the reality of Matias's situation (line 27).

Extract 4 exemplifies the use of inevitability claims in response to a relative's assessment of a resident's condition. It also shows that inevitability claims can be used to raise awareness of the terminal nature of dementia. It is from the first care plan meeting after a resident's transition to the nursing home. Present are the resident's two adult daughters, Ira and Mia, the nursing home manager (Ma1), and two nurses (Nu1 and Nu2). The meeting takes place in a meeting room. Alvar, the resident, is not present. Before the extract, the participants have discussed how Alvar has settled in the nursing home. The staff have updated Ira and Mia that Alvar has been calm and sociable but also restless at night (data not shown).

At the beginning of Extract 4, the manager asks Nurse 2 about Alvar's appetite (line 01). Nurse 2 assesses it as good but also alludes to occasional problems with the activity of eating ("there's a bit of messing"; line 02). This leads to a discussion about Alvar's eating habits and likes before his transition to the home (data omitted). Nurse 1 subsequently returns to present-day considerations and reports that Alvar has lost weight (lines 42–43). Mia emphatically agrees with a high-pitch *nii* ("yeah") and assesses the situation as "peculiar" (line 46), thus treating it as a puzzle, arguably because of the conveyed contrast between Alvar's weight loss and his good appetite and being "omnivorous" (lines 42–43). This assessment can be heard as implying the expectation that Alvar's weight could remain stable and may raise the possibility of inadequate care. It makes an account relevant, which the manager delivers as an inevitability claim from line 48.

Extract 4. (Meeting 6; Nursing home 2; Ira = resident's adult daughter; Mia = resident's adult daughter; Ma1 = manager; Nu1, Nu2 = nurses, starting at 32:33)

```
01 Ma1: Nii mites se (.) ruokahalu on vissiin hyvä vai kuinka.
        So how about (.) the appetite is good I presume or.

02 Nu2: *↑On hyvä ruokahalu. välillä öö hiukan sotkemistaki tulee
        *↑The appetite is good. Sometimes erm there's a bit of messing too
        *NODS

03      mut ei aina, että ajoittaista
        but not always, so just occasionally.

((omitted 38 lines of talk about Alvar's likes and eating habits
before the transition))
```

```
40 Ira: Et ei hänel talous siihen kaatunu et jos hän
        So it did not ruin him financially even if he

41      niit viinirypäleit osti sit vähän.
        kept buying grapes.

42 Nu1: Et se et vaik hänel on hyvä ruokahalu ja hän on
        But even though he has a good appetite and he is

43      kaikki<ruokainen> [niin] ni hänel on kyl paino pudonnu.*
        omni<vorous> still he has indeed lost weight.          *
                                                              *SMALL NODS
                                                              *NU2 NODS

44 Ira:                  *[Mm.]
                         *[Mm.]
                         *NODS

45 Ma1: Juu.
        Yeah.

46 Mia: ↑Nii, Se on jännä.       [>joo,  joo,<  ]
        ↑Yeah, That is peculiar. [>yeah, yeah,< ]

47 Nu1:                          [*Nii, joo.    ]
                                 [*Yeah, yeah.  ]
                                  *SMALL NODS

48 Ma1: Mut se on     vähän tätä, *kyl se on     hyvin tyypillistähän
        but DEM be.3SG little DEM  MOD DEM be.3SG very  typical.CLT
        But it is sort of part of this,*it is 'as we all know' very
                                        *NU1 NODS REPEATEDLY

49      se  on     [tälle   sairaudelle,         ]
        DEM be.3SG  DEM.ALL  disease.ALL
        typical    [for this disease,            ]

50 Nu1:         [ Juu, se on.                    ]
                [ Yeah, it is.                   ]

51 Mia:         [Nii et se liittyy tähän.        ]
                [Yeah so it is connected to this. ]

52 Ma1: Kyllä ↑kaikki  [melkein] jossain   vaiheessa   *laihtuu.
        MOD    everyone almost   somewhere phase.INESS lose.weight.3SG
       'Indeed' [almost ] ↑everyone at some point will *lose weight.
                                                        *NODS

53 Ira:                 [Joo.   ]
                        [Yeah.  ]

54 Mia: Joo.*
        Yeah.
           *IRA NODS

55 Ma1: Ja: ja tuota sitte- sitte se usein tasaantuu *mun
        A:nd and well then- then it usually stabilizes *in my
                                                        *NU1 NODS
```

```
56        mielestä tietyssä vaiheessa. Et mennään pitkään
          opinion at a certain point. So for a long time people stay

57        sillai *suht koht samassa.
          about   *the same.
                  *MOVES HAND HORIZONTALLY FROM LEFT TO RIGHT

58 Mia:   Joo,
          Yeah,

59 Ma1:   ja sitten tota niin niin, taas sitten myöhemmässä vaiheessa
          And then erm well, again at a later phase

60        vielä niin tuntuu et sitte- *sit tulee se semmonen
          it seems like then-         *then comes a phase
                                      *NU1 NODS

61        ku ei tavallaan *elimistö enää *(.) ime.
          when *the body sort of no longer *(.) absorbs.
                *MOVES HAND DOWN FROM ABDOMEN TO LAP
                                               *MIA NODS
62        *Se ruoka ei imeydy enää.
          *The food does not get absorbed.
          *ROTATES HAND FROM SIDE TO SIDE

63 Mia:   *Joo.
          *Yeah.
          *NODS
```

The manager's turn-initial *mut* ("but"; line 48) challenges the presupposition that Alvar's weight loss is surprising or unexpected. The *kyl*-preface frames the manager's position as departing from Mia's assessment while inviting her to revise it (Hakulinen, 2001). The manager normalizes weight loss as a "typical" consequence of dementia, which is not named and only referred to as "this disease," thus treating it as something that the relatives already know (lines 48–49). Deterioration is further established as familiar through *-hän* (*kyl se on hyvin tyypillistä**hän** se on* "it is **'as we all know'** very typical"; line 48). The typicality of the situation is enhanced by the adverb *hyvin* ("very").

Nurse 1 displays agreement (line 50). Mia displays recognition (*Nii* "Yeah") and formulates the manager's claim as the solution to the puzzle ("so it is connected to this"; line 51; regarding *nii* + aligning elaboration as a response to affiliation-relevant utterances, see, Sorjonen, 2001, p. 181). The manager goes on to describe weight loss as something that *almost everyone* encounters (line 52)—a generalization that provides epistemic support to her prediction. The turn-initial *kyllä* ("indeed") formulates this as general knowledge and adds weight to the speaker's argument (Hakulinen, 2001, pp. 185–187).

Following the relatives' acknowledgments (lines 53–54), the manager moves from accounting for present symptoms to guiding expectations about the future. She presents the possibility that deterioration could level off and Alvar's weight remain stable for a long time (lines 55–57). Her horizontal hand gesture (line 57) proposes that Alvar's decline will plateau. This balances the inevitability claim with a brighter formulation of what lies ahead. This shift from negative to positive is found throughout our collection (see Extract 1, lines 32 and 34; Extract 2, lines 18–19; and Extract 3, line 27). As noted, it is part of the careful calibrations whereby the staff walk the line between fostering realistic expectations without causing undue concern and reassuring without instilling false hope. Indeed, the manager goes on to invoke the eventual, terminal outcome of Alvar's disease (lines 59–62). This is framed as a more

extreme version of the present situation, in which Alvar's body already appears not to be absorbing nutrients, and alludes to the EOL. At the same time, the manager softens these predictions by avoiding mentioning Alvar directly and referring to "the body" instead—a formulation that also endows the prediction with a sense of biomedical certainty.

To summarize, inevitability claims produced in response to relatives' actions instruct them to make sense of the resident's deterioration in the context of dementia, which excludes the staff's responsibility and concurrently prepares them to witness further deterioration in the future.

Discussion

We investigated practical problems faced by participants in making sense of PLDWs' deterioration in the context of care plan meetings between relatives and nursing home care staff in Finland. PLWDs in long-term residential care are socially construed as "retired"—their links to mainstream social life having been severed. They can be experienced and treated as having undergone "social death" (Seale, 1998; Sweeting & Gilhooly, 1997) and as having entered an extended period of rest in a setting meant to fill the time preceding biological death. Care plan meetings can thus be expected to happen in the context of shared awareness of PLWDs' declining health and gradual transition to the EOL.

However, the long-term, chronic, and cyclical nature of dementia also makes its impact on functional ability and life expectancy difficult to disentangle from the effects of aging (Kellehear, 2007). Relatives and staff can face the practical problem of attributing observed deterioration to either dementia or the effects of aging. Additionally, in the context of growing complaints and mistrust about residential care (Kangasniemi et al., 2021), observed deterioration may raise the specter of inadequate care. The practical problems that participants face in the care plan meetings we investigated are thus situated at the intersection of the ambiguities inherent to deterioration in the context of dementia, and the management of relationships between service providers and service users within the ongoing struggles of accountability faced by institutional care.

The care plan meetings are chiefly occupied by the activity of updating the relatives about the resident's health (see Extracts 1 and 4), as well as discussing associated practical matters (Extract 3), hopes and concerns (Extract 2). The staff use the social action we identified—the inevitability claim—to attribute observed and reported deterioration to dementia, which concurrently rules out poor care as a cause and directs relatives' expectations about future deterioration. The staff design and position inevitability claims in ways that manage practical concerns inherent to the delivery of updates.

In terms of design, constituting dementia as an already familiar reality manages epistemic considerations by avoiding claiming that relatives are unaware of the realities of dementia. It also confers epistemic force to inevitability claims by treating dementia and its consequences as an established, taken-for-granted reality.

In terms of positioning, inevitability claims are part of broader calibrations whereby the staff walk a fine line by conveying reassurance without instilling false hope, and by fostering realistic expectations without causing undue concerns. The staff's management of updates thus shares an important feature with how healthcare professionals manage news deliveries as documented in prior studies: they work to achieve an "equilibrium" (Stivers & Timmermans, 2017) of hope and anticipation of inevitable deterioration.

Finally, attributing deterioration to the inevitable, and thus uncontrollable, progression of dementia arguably introduces an element of "rationality" (Maynard & Frankel, 2006) in a scenario characterized by the disruptive effects of illness on the sense of hope and control that otherwise informs the natural attitude of everyday life. Turning toward the inevitable may be a way of introducing an element of reassurance by construing deterioration as normal in the context of the altered reality brough on by dementia. This works alongside other actions whereby the staff work to promote "palliative hope" (Peräkylä, 1991) by promising that the resident will be well looked after, and that the staff will do everything in their power to facilitate a peaceful transition to the EOL.

To our knowledge, this study is the first to examine discussions about illness progression and EOL in the contexts of nursing home care and dementia (cf., Parry, 2024; Wu & Zhang, 2024). Compared with such settings as oncology and palliative care, invoking the inevitability of future deterioration and death is less accountable in the nursing home setting—possibly because the staff work in proximity to the residents, provide comfort care rather than curative treatment, and because of the residents' old age, institutionalization, and diagnosis of dementia. It would therefore be worthwhile to compare how discussing illness progression and EOL is treated as more or less accountable across different healthcare settings.

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