Nurse managers' perceptions of care environment supporting older people's ability to function in nursing homes

Running head: **Care environment and ability to function**

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Nurse managers' perceptions of the care environment: supporting residents' ability to function in nursing homes

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Abstract

Aim: To describe nurse managers' (NM) perceptions of the care environment in nursing homes and how residents' ability to function may be improved.

Background: The care environment, considered under physical, social and symbolic dimensions, can be used to maintain and enhance residents' ability to function.

Methods: An exploratory, descriptive qualitative research design based on focus groups (n=4) was used. Fourteen NMs from six nursing homes in Southern Finland participated during 2014. Data were analysed using content analysis.

Results: The physical environment enables self-management, by facilitating a cosy, homelike and aesthetically-pleasing environment and by the design of internal structures and assistive devices. The social environment was described as enabling by providing both private and communal spaces, encouraging personal privacy and self-determination whilst supporting communal interaction and involvement. The symbolic environment was described as supporting a personal culture, care culture development and connecting the components of care perspectives in the community including nursing principles, recognizing and accepting variation in approaches to care.

Conclusions: Development in the care environment requires more innovative approaches especially in the social and symbolic dimensions.

Implications for nursing management: The results provide a framework for NMs for analysing and developing the care environment supporting residents' ability to function.

Keywords: care environment, older people, ability to function, long-term care, nurse managers

Introduction

The care environment of nursing homes has a strong impact on the health and wellbeing of older people, but this is not reflected comprehensively in the design of institutional care and rehabilitation environments. (Ulrich et al. 2008). The physical environment is an important component of the quality of life for all people (Nordin et al. 2015) and a homelike environment is important for many older people, when a nursing home becomes their activity base as they grow older (Bradshaw et al. 2012, Rodríguez-Martín et al. 2013). Previous studies have focused on the physical environment, and other types of environment, such as the social and especially the symbolic, have received less attention.

Although the care environment and care providers' expertise has been found to have an impact on care outcomes and services (Suhonen et al. 2009), the use of residents' own resources to enhance the care environment (Van Steenwinkel et al. 2017) and nurse managers' (NM) activities in developing it, have been neglected. The expert use of the care environment can be an important means of care and rehabilitation (Sawamura et al. 2013, Mercante et al. 2014). Conversely, admission to a nursing home may cause the loss of independence and functional decline in older people (Zisberg et al. 2015). These losses are recognised by nursing home managers but the progress, mechanisms and risk of this decline are poorly understood (Pynnönen et al. 2012). One reason for a functional decline may be that residents in nursing homes are generally inactive and spend most of the day sitting or lying in bed (den Ouden, et al. 2015). Moreover, nursing care environments can be restrictive causing adverse effects, such as low mobility and increased health problems, including functional decline (Zisberg et al. 2015). These results of a restrictive environment may demonstrate how the care environment can become an under-used resource in the care of older people, especially in the support of self-management, independence and the ability to function (Nordin et al. 2015). NMs have a key role in the leadership, facilitation and organisation of

the care environment and the rehabilitative and functional management of the residents. Having this key role means that NMs' perceptions of the care environment are important though they have been captured rarely.

The aim of this study was to describe NMs' perceptions of the care environment in support of older residents' ability to function in nursing homes and how this situation may be improved. The goal was to identify the core elements of the care environment that may be enhanced for the benefit of the nursing home residents.

Background

The care environment, according to Kim's typology (2010) has been defined in terms of the physical, concerned with the structures within the institution, the social, concerned with people's interactions and the symbolic, concerned with culture, language, religion/spirituality and society norms Other studies have considered the care environment in terms of people, processes and equipment (Zimmerman et al. 2013), and the built environment, including information technology (Cook et al. 2010) and architecture (Van Steenwinkel et al. 2017). The elements within these studies (Zimmerman et al. 2013, Cook et al. 2010) facilitate an understanding of the care environment but not how this environment acts on and with the residents. Kim's Typology (2010) was used in this research because Kim classifies the care environment in terms that residents and staff can both use to describe the care environment

The physical care environment in the nursing home is spatially different from the family-based home environment containing different types of rooms, corridors and equipment. Physical environment designs, providing balanced and controlled stimulation, featuring assisted orientation that compensates for disability and promotes involvement in everyday activities, have been found by researchers to be useful (Sawamura et al., 2013). However, this compensation and promotion

depends on the NMs' and staff's effectiveness in harnessing active living and recreational activities (Bradshaw et al. 2012). The social care environment is also different from the family home environment. The nursing home has a large number of staff who work shifts and so change from day-to-day and relatives and friends are likely to be absent for much of the time. The symbolic care environment is also likely to be very different from the family home as residents are often expected to play certain roles, express certain attitudes and accept values which influence their behavior and attitudes (Kim, 2010). The residents' ability to function in terms of their physical, cognitive, psychological and social ability (Candela et al. 2015 within the physical, social and symbolic dimensions of the care environment, is essential for them to maintain an active role in this local society (Bradshaw et al. 2012).

Functional ability can be maintained and improved in an encouraging physical environment. It has been demonstrated that by modifying the environment, facilitating individuality and increasing the freedom to move, many positive changes in older people's functional ability and well-being occur (Cioffi et al. 2007, Van Steenwinkel et al. 2017). Wilkes et al. (2005) reported that improving lighting, increasing the size of windows and providing free access to the garden, decreased patients' aggression and anxiety, especially among people with memory disorders. Marquardt & Schmieg (2009) found that simple architecture and smaller nursing home populations improved residents' ability to find their way back to their bedroom from the dining room.

NMs consider a homelike care environment providing a social environment involving the residents' families, meaningful recreational activities and community connections, to be central to older people's quality of life (Murphy et al. 2008, Bradshaw et al. 2012). It has been reported that NMs believe that small changes in the care environment, to become more home like, can have positive effects on residents' health and behavior (Shield et al. 2014). Although older people in care

facilities consider the role of the NM to be significant in the development of the care environment (Murphy et al. 2008) there is a paucity of research that analyses their views.

Methods

Design, settings and sample

An exploratory, descriptive, qualitative design based on focus groups with nurse managers, were used to elicit the free description of the participants' experiences and feelings (Joyce 2008) to gain an authentic insight into the care environments they manage. Six public nursing homes in two cities in southern Finland, offering full-time care services for older people, provided the settings for the research. The number of residents in these public nursing homes ranged from 14 to 33, and most homes focused on the care of people with memory disorders. The sampling for each focus group was purposeful (Polit & Hungler 1999). Each person selected for a focus group was a NM who worked in a nursing home at the in-patient level and had at least 2 years' experience in this managerial position. Potential participants were contacted by the chief nurse directors of the cities. After a discussion with each potential participant about voluntary participation, the contact details of those who were interested were passed to the researcher.

The participants (n=14), varied in their age, qualifications and experience. All the participants were females aged 34–64 years and had between 6 and 32 years' experience in older people's care and between 2 and 20 years' experience as NMs. The participants had training and education in management and leadership at different levels. The allocation of participants to each focus group was managed so that variations in age and experience were represented in each group.

Data collection

The data were collected from four focus groups of between two to five participants in June 2014. The focus group moderator used a pre-prepared list of three themes, the physical, social and symbolic care environments (Kim 2010) and open-ended questions, (Table 1) based on the research aim to nurture discussion and disclosure (see Litosseliti 2003). Kim's typology, (2010) based on nursing theory, is fundamental work providing a broad view of the care environment and so is able to be used to facilitate the themes of the focus group interviews. Over the period of each focus group the participants discussed the most important issues as they described the care environment in their own organisation and how this environment supported their residents' function. The focus groups were audio-recorded and ranged from 61 to 64 minutes, producing 251 minutes of speech. These audio recordings were supplemented by memos taken at each focus group by a focus group assistant.

Insert Table 1 about here

The two researchers, a moderator and assistant, conducted the focus group interviews in quiet meeting rooms at the organisations participating in the study. Each focus group began with a discussion of the study and study conduct before individual informed consent forms were signed. The moderator (TK) presented the themes and facilitated discussion in the group eliciting participants' experiences, views and thoughts about the research topic.

The first focus group interview was a pilot study and was used to establish how best to develop discussion in the groups, make memos and manage the roles of the moderator and assistant. As there was no need reformulate the protocol after the pilot study, the data collected were included in the analysis. Saturation (Polit & Hungler 1999) was thought to have occurred at the end of the third focus group which was confirmed in the fourth focus group.

Analysis

The focus group recordings were transcribed verbatim and the text was analysed in light of the research aim and the three major categories of Kim's (2010) typology. In this research, we used latent content analysis, in the process of identifying, coding and categorizing the primary patterns in the data, searching for meaning in context (Graneheim & Lundman 2004, Patton 1990). Inductive latent content analysis was used to identify the elements of the care environment that support the residents' ability to function and their social relationships without designating significance. These concepts were identified, coded and sorted into sub-categories and categories (Graneheim & Lundman 2004). The various codes were compared using the constant comparison method; those with similar content were sorted into sub-categories, and then the three categories (Figure1) (Graneheim & Lundman 2004). This analysis was conducted by the first author (TK) independently and then another researcher, also independently, repeated the process. Finally, the codes, sub-categories, categories and theme were discussed and analytic consensus was obtained within the wider research group. An example of the analysis is in Table 2.

Insert table 2 about here

Ethical considerations

The study was conducted according to scientific and ethical standards (The European Code of Conduct for Research Integrity 2011) and used voluntary staff members. In accordance with national legislation, approval of an ethics committee was not necessary (Medical Research Act 2010/794) but permission to conduct the study was obtained from the chief administrators (HEL 2014-000442, VD/1424/13.00.00/2014) of the research settings. Information about the purpose of the study, voluntariness, anonymity and confidentiality was ensured orally, when potential participants were first invited to participate in the study and in writing before the focus groups began. Also at this time participants had the opportunity to ask questions about the study and its conduct and withdraw from the focus group and study.

Rigour

The rigour of the procedures was ensured by taking memos in the focus groups, recording and transcribing the discussions verbatim and in the careful analysis of the discussions and memos (Graneheim & Lundman 2004). The trustworthiness and validity of the study were assessed in terms of credibility, dependability confirmability and transferability (Krueger & Casey, 2009).

Credibility was attained by the inclusion of active and experienced NMs from different backgrounds in terms of age and work experience in the focus groups. These variations in the participants' experiences led to fruitful, inspiring and many-sided discussions. As the language in the focus groups and subsequent transcriptions were different from the reporting language, the two focus group researchers identified the elements, coded them and created the sub-categories independently.

Dependability was ensured in two ways. Firstly, the *a priori*, predefined themes and open-ended questions, used in the focus groups, helped to control the discussion and kept it focussed. Secondly, using the same open-ended questions and the same moderator and assistant helped to make the approach to the focus groups consistent (Milne & Oberle 2005). Lastly, the pilot study helped the researchers improve dependability through practice.

Confirmability was ensured by having a lead researcher who conducted both the interviews and preliminary analysis. One different senior researcher analysed the data to confirm the division of the data, codes and sub-categories, into the predetermined categories, (Figure1) according to the predefined themes, then the whole analytic process and results were discussed in the research group. The tentative structure developed from this process was then confirmed in the research group using text samples. The most representative participants' quotes have been included in the Findings

section to facilitate understanding and demonstrate the validity of the interpretations. Transferability was optimised by an in-depth description of the study conduct enabling repetition of the procedures.

Findings

The care environment in support of residents' ability to function

Analysis of the data showed that the three categories (Kim 2010) (the physical, social and symbolic environments) (Figure 1) explained the participants' perceptions of the residents' ability to function in the care environment.

The physical environment in support of the residents' ability to function was described by participants in two sub-categories: **enabling self-management** and **a comfortable, cosy** environment (Figure 1). Participants considered that the environment enabling residents' self-management should be s*afe, unimpeded, rehabilitating and providing appropriate equipment or devices*.

The environment was described as safe when the national legislation was followed and environment and planning guidelines were considered in the care environment. This safety included tested fire alarm systems and safe building and content materials. In addition, it was perceived that building illumination and unimpeded walkways were important for increased, safe activity and ease of mobility. However, some rooms were described as full of furniture and equipment which hindered mobility. Environmental technology, such as alarms embedded in the built care environment, were often used to improve safety.

The physical rehabilitating environment was regarded as highly important featuring the availability of outdoor recreation. However, participants described how the location of the nursing home had an impact on how often and what kind of outdoor recreation could be made available. Physical

rehabilitation opportunities inside the nursing home included the use of staircases and gyms with easy-to-use equipment and going for walks. Motivation for improving mobility and taking part in activities was supported by, for example, watching animals and listening to birds singing.

> *.. the location of this nursing home is good… it is easy to go outdoors and do outdoor recreational activities … shopping centre with activities is near… I mean coffee shops, museums, library... such services encourage older people. We have a forest nearby and nature... listening to the birds singing.* (Group 2)

Participants stated that almost all older people living in nursing homes have some equipment and assistive devices to support mobility, such as a Delta frame or walking stick. Handrails and equipment for supporting staircase ascent were regarded as important to assist self-management and the ability to function, for example in the toilet. Equipment situated in the environment was regarded as suitable when there was an opportunity to adapt and tailor it to the needs of individuals, for example toilet seat heights. It was recognised that some assistive devices help staff but do not necessarily help the residents. For example, equipment used to raise and lower beds may not encourage older people to use their own resources to get in and out of bed.

A comfortable, cosy environment was described by participants as *aesthetically pleasing and home-like*. An aesthetically pleasing environment was considered important and included decorations and furnishing. An environment like this, tailored to individual preferences, facilitates ease of movement and motivates residents to increase mobility. Colours and materials, for example in curtains, scented flowers and plants were considered important parts of the aesthetic environment. The aesthetic atmosphere also included an ordered environment providing support for residents to function well. Residents who used wheelchairs or were moved in beds were taken into consideration by making decorations, such as paintings and art, visible from the bed or while sitting.

A *home-like environment* was facilitated by allowing residents to bring their own important personal belongings to their private spaces such as bedrooms. The participants thought that residents need to be able to have their rooms decorated to their own specifications.

> *Residents' own rooms are beautifully decorated and furnished … according to [residents'] own wishes and hopes … The family members have brought them [furnishings]and nurses have facilitated the decorating… We consider it important…*(*Group 1)*

The participants stated that the physical situation of the nursing home and rooms were important in providing opportunities to help residents follow life outside the nursing home including following the seasonal changes which engendered a sense of time.

The social environment in support of older people's ability to function included two sub-categories: **communal and individual environment** (Figure 1). The **communal environment** included two codes: *supporting involvement and supporting communal interaction*. Involvement in recreational activities was facilitated by many initiatives and was considered highly important by the participants. There were many festival-related activities and events organized in the nursing homes for example, relatives' day, Mother's Day and Christmas, which support family member visits to nursing homes. Recreational activities included games, garden and reading groups.

> *We have a group for playing games, recreational support groups, garden group … these include certain individuals, residents and nurses*…(Group 3)

Recognition of residents' past hobbies and background was considered in the provision of recreational activities by the participants. Participation in activities not previously undertaken by the residents were also organized. Facilitation of the communal environment enabled effective interaction in the whole organization when staff from professions other than nursing was involved.

The communal environment also included residents' family members, significant others and third-sector volunteers. The participants thought that it was most important for family members to participate in the activities and daily lives of the residents of the nursing home.

The individual environment included two codes, *respecting self-determination and supporting privacy* (Figure 1). For the participants, r*especting self-determination* meant having the opportunity to take part in day-to-day decisions and to make choices concerning participation in recreational activities in the nursing home

> *Elements of self-management and their life situation are important…. they should be supported, as one can easily become institutionalized and leave all old activities behind…*(Group 4)

Respecting self-determination was associated with retaining and maintaining residents' life experiences and independence. Respecting and facilitating *privacy* meant having cognitive privacy with dignity when needed and being able to maintain one's own spatial and physical privacy.

The symbolic environment in support of older people's ability to function included three sub-categories: **supporting personal culture, supporting nursing culture development and connecting care perspectives.** (Figure 1)

Supporting personal culture was described by participants as using the environment to *support and* enable *individuals' spirituality* and spiritual needs whilst recognising *each individual's cultural background*. The practical recognition of spirituality was described as the need for the provision of religious activities, prompting the organization of activities around seasonal holy days. Theologians were invited to the participants' nursing homes and religious services were organized frequently

using symbolic religious artefacts if the residents were religious. Faiths were recognized by the organizations and one nursing home had a silent room for spiritual activity.

> *In our nursing home religion is ever-present, in the residents' lives and environment…*(Group 1)

The recognition of each resident's cultural background was facilitated by enquiring about their preferred current cultural activities and supporting those they may have had earlier in their lives, for example music. A more multicultural approach was thought to be necessary in the future, in line with changes in the residents' cultural heritage. Multicultural issues were also considered from the staff's perspective whose variety of languages and cultural habits contributed to the symbolic environment within the care and care culture. These cultural habits of staff members were considered an important addition to the cultural milieu of the nursing home supporting older people's ability to function.

Supporting nursing culture development was described as *developing the care culture and environment*. Discussions included the reduction in the task oriented "doing for" approach to the residents which undermined their ability to function independently, moving to a more supportive and facilitative role which, where possible, would lead to improved rehabilitation. A rehabilitative and restorative care approach was described as a challenge in many nursing homes as staff members spent little time supporting self-management and independence, facilitating dependence rather than supporting residents' ability to function. The need to change the staff perspective from a dutiful approach to one that supports individual residents personally was described. Participants explained that this included an understanding of the need to support the health, functional ability and self-management of each resident. A change in the work culture would require courage, patience and extended staff skills. The participants described their own role in this development as that of a

supporter, mentor, facilitator and leader and that relevant education would be required for care culture and environmental development.

Connecting care perspectives was the last sub-category described in the symbolic environment and included two codes, *nursing principles and codes*, and *recognizing different care cultures*. The symbolic environment includes the nursing principles and codes concerned with ethical issues and humanity. These principles and codes generate written and unwritten norms guiding nursing care and the way staff members interact with the residents. Norms such as respectful interaction, recognizing individuality and a person-centred approach to care were discussed by the participants. Norms related to work in the nursing homes were also modified by people from different cultures. The participants described differences in care cultures arising from different care approaches and staff attitudes to the residents. For example, staff from different cultures were noted for their positive and respectful, patient and humane approaches to care and the way they supported older people's ability to function. In some nursing homes, language difficulties between staff and residents reduced communication to using facial expressions, gestures and touch which may facilitate older people's ability to function.

Discussion

This study provided a description of how the nursing home environment currently supports older people's ability to function in nursing home context and some opportunities to improve this situation. Nurse managers identified a wide range of care environment characteristics, processes and activities relevant to the physical, social and symbolic environments (Figure 1). However, these descriptions represented the views of a small number of NMs in six nursing homes about the opportunities to support older people's ability to function, and sometimes were not descriptions of current work in the nursing homes. Descriptions about the physical environment in supporting older

people's ability to function were many-sided and wide. Surprisingly, the viewpoint in the description of the symbolic environment was more about staff perspectives, describing, for example, the norms and the presence and activities of the staff. Previous studies have reported that the care environment provides an important opportunity for restoring residents' ability to function (Sawamura et al. 2013, Mercante et al. 2014, Van Steenwinkel et al. 2017), but the result of this study shows that it can also easily threaten independence if the nursing care does not seize these opportunities.

Participants' descriptions of the physical environment were detailed, focusing on the structures within the nursing home, such as the safe and accessible facilities and the use of assistive devices (Figure 1). This environment was described from a duty-based and safety perspective concerned with litigation, protection and harm-avoidance. This finding reflects the concern about the relationship between the dangers of the physical environment and residents' mobility previously reported (den Ouden et al. 2015). Moreover, safety has been strongly linked to hospital and institutional care and there is lack of studies on safety in a home-like environment. This focus on safety by the participants may arise because many nursing home regulations about the physical care environment, in countries where this is regulated, are concerned with safety (Hervey 2010).

In the line of previous studies, it was found that the furniture and decoration of corridors, public spaces and individual rooms affects older people's ability to function. These physical structures and designs can be designed to prevent functional decline (Hujala & Rissanen 2011), especially in people with dementia (Zimmerman et al. 2013). Additionally, a home-like environment is considered important in nursing homes (Bradshaw et al. 2012). The sentiments of the participants reflected these insights though current nursing homes have been reported to be more hospital-like, traditional and institutional, with strict rules and structures (Tuominen et al. 2016). The participants

in this study recognized the need for a change in attitudes towards developing a care culture and environment that supports older people's ability to function and live comfortably in nursing homes. This change would help the nursing home move towards having less rules and to become more person-centred. Surprisingly, most participants did not consider the wider opportunities provided by information and health technologies, such as smart spaces (Cook et al. 2010), as part of the environment that might also help to individualize care. However, the participants did mention alarm systems and conventional equipment designed to enhance or safeguard older people's mobility.

The description of the social environment which facilitates older people's ability to function, was narrower compared to that of the physical environment, identifying two key elements, the communal and individual (Figure 1). This finding contradicts those of an earlier study of nursing home residents which found that older residents' own free will was not actualized (Tuominen et al. 2016) which may be due to the architecture not supporting independence (Van Steenwinkel et al. 2017). The barriers to a freer social environment described by these earlier studies were nurses' unethical attitudes, institution rules, older people's attitudes, physical frailty and dependency (Tuominen et al. 2016). The reason for the apparent discrepancy may be that the NMs in this current study described the ideal use of the environment or the current opportunities existing in the nursing homes to facilitate older people's ability to function.

The symbolic environment was described as recognizing the organizational culture, supporting cultural care development and connecting care perspectives. Discussions about cultural care focused on annual festivals. In these terms, helping residents to maintain their customs was considered important. Related to maintaining customs, the recognition of seasonal changes was important to the participants, helping the residents with time orientation. This finding concurs with (Juvani et al. 2005) who found that older people have a connection with nature making different seasons of

special importance. This connection occurs even though the northern physical environment is, at times, a threat to the safety for older people (Juvani et al. 2005).

When focusing on less tangible aspects of the symbolic environment the descriptions of that were less full compared to the physical and social environments and may need further consideration. Also, during these less tangible subjects, participants sometimes moved away from describing the current symbolic environment to including the changes required and the viewpoint changed from residents to staff. For example, in discussions about how staff worked, their attitudes to nursing care and the need for change, the current interventionist approach to care was highlighted. The participants recognised the need to move from a task-oriented approach to work towards a more person-centered approach to care and from a nursing and provider point of view towards resident perspectives. This may mean that the symbolic environment in supporting older people's ability to function is an under-used resource currently but that nurse managers have ambitions to make positive changes. Changing to a more person-centered approach may provide more opportunity for both staff and residents recognise important elements of the symbolic environment such as individual preferences and past life experiences. Development of staff's cultural competence and the use of staff from multicultural backgrounds may help in developing this symbolic environment.

Limitations and future studies

The small number of participants limits the transferability of the findings. However, studies from the NMs perspective, key players in the development of the care environment, are rare making these findings more important. Methodological literature suggests that focus groups should be large enough to produce a variety of perspectives but not so small that the discussions become fragmented (Rabiee 2004). One focus group was reduced to two participants because two other participants withdrew from the study to return to work. The small focus group provided some good

information about the topic and it was considered important and ethical to include this data in the analysis. The last limitation is that all the participants were female. This situation is common in Finland, and therefore the results of this study are transferable nationally within Finland.

Though this was an exploratory inquiry into the perceptions of NMs, it could have been improved by including an observational approach used to augment the focus group data. Further studies could analyse the physical care environment using detailed observational assessment schemes to provide a more rounded analysis. The symbolic environment warrants further investigation from the residents' point of view. The results provide a starting point for further analysis of the care environment. Future studies will benefit from a multidimensional approach by including perspectives from residents, their family members' and other stakeholders and using assessment methods such as photo-elicitation with the residents.

Conclusion and relevance to practice

This exploratory study examined the perceptions of NMs of the nursing home care environment and how this supported the residents' ability to function. Although the physical environment was described at length, the social and to a greater extent the symbolic environment of the care environment were less fully described, identifying instead rather conservative and obvious opportunities to support residents' ability to function. Whilst this is important, it highlights the need for further investigation to develop new and innovative approaches that will facilitate the description and development of the social and symbolic care environments more fully. The results of this study indicate the need for a move towards the provision of a more aesthetically pleasing, person-centered, nature-connected environment in nursing homes that operate within an umbrella of safe, harm avoiding care processes. These care processes include for example, visual, spatial and interactive elements of care.

Implications for nursing management

This study examined the perceptions of NMs about the care environment who described some opportunities for realistic and useful improvements. NMs have a key role in recognising opportunities, planning and implementing the developments required to facilitate improvements in nursing home residents' ability to function. The results of this study can be used by NMs to analyse the care environment in individual nursing homes, build on the data provided in this study and make improvements. The use of new technologies, largely missing from the perceptions of the participants in this study, could also be explored.

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Table 1. Focus group topics

Main topic: Nurse managers' perceptions about the elements of the care environment that supports residents' ability to function
1. The physical environment
- Describe physical environment you have in your department/ unit
- What support for facilitators of older people's ability to function in the physical environment is offered?
-What are the important elements?
2.The social environment
- Describe social environment you have in your department / unit
- What support for facilitators of older people's ability to function in the social environment is offered?
- What are the important elements/
3.Symbolic environment
- Describe symbolic environment you have in your department / unit
- What support for facilitators of older people's ability to function in the symbolic environment is offered?
- What are the important elements?

Table 2. Example of data analysis, codes, sub-categories and categories describing nurse managers' perceptions of the care environment

Transcribed text	**Codes**	**Subcategories**	**Categories**	**Theme**
Elements of self-management and their life situation are important…. they should be supported, as one can easily become institutionalized and leave all old activities behind *In supporting ability to function the residents would have power to decide, that they participate and decides of their own matters* *An individual feels well when having a say in their own issues…* *When many activities are available, it is important that residents have a possibility to decide… that the nurses are not assuming… and moved without asking…*	Respecting self-determination	Individual	Social care environment	Care environment supporting older people's ability to function
Existing possibilities for privacy… *Respecting …having own space* *Mastering own space…* *Cherishing privacy…*	Supporting privacy			

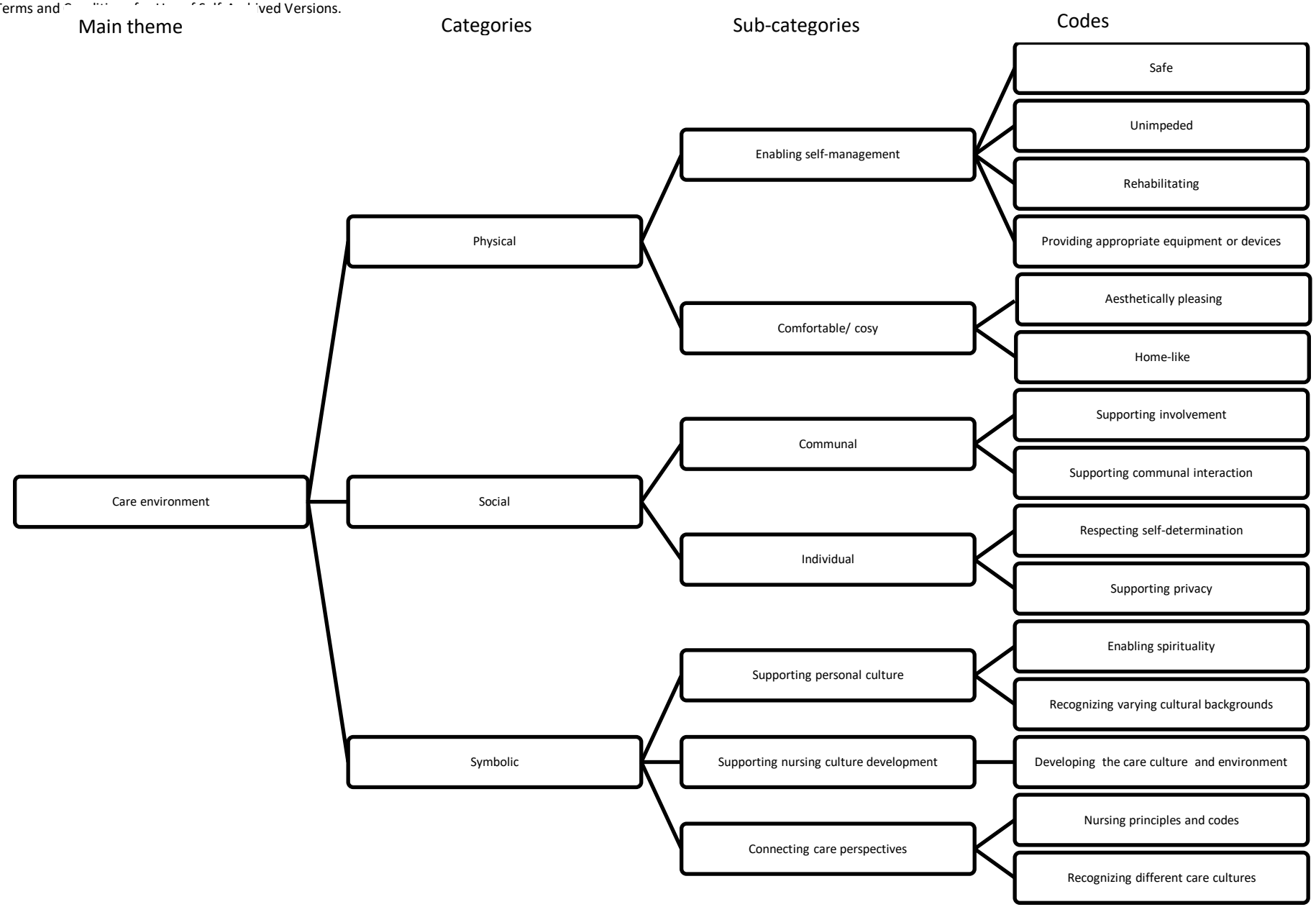

Figure 1. The care environment supporting older people's ability to function optimally