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Residents' experiences of interpersonal factors in nursing home care: A qualitative study

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ABSTRACT

Background: With life expectancy lengthening, the number of those who will require care in a nursing home will increase dramatically in the next 20 years. Nursing home residents are frail older adults with complex needs, dependent on advanced nursing care. Long-term residents in nursing homes have long-term relationships with the nurses, which require a unique approach to the interpersonal aspects of nursing care. Understanding what is experienced as care quality, including quality of interpersonal processes, requires insight into the residents' perspectives for best value in care to be realized.
Objective: Main objective was to describe the nursing home residents' experience with direct nursing care, related to the interpersonal aspects of quality of care.
Design: A descriptive, exploratory design was used.
Settings: Four public municipal nursing homes in Norway with long-term residents were purposely selected for the study.
Participants: Fifteen mentally lucid residents were included. The inclusion criteria were aged 65 and over, being a resident of the nursing home for one month or longer, and physical and mental capacity to participate in the interview.
Method: In-depth interviews with the residents were performed. The transcribed interviews were analyzed using meaning categorizing.
Results: The residents emphasized the importance of nurses acknowledging their individual needs, which included need for general and specialized care, health promotion and prevention of complications, and prioritizing the individuals. The challenging balance between self-determination and dependency, the altered role from homeowner to resident, and feelings of indignity and depreciation of social status were key issues in which the residents perceived that their integrity was at risk in the patient–nurse interaction and care. Psychosocial well-being was a major issue, and the residents expressed an important role of the nursing staff helping them to balance the need for social contact and to be alone, and preserving a social network.
Conclusions: Quality nursing care in nursing home implies a balanced, individual approach to medical, physical and psychosocial care, including interpersonal aspects of care. The interpersonal relationship between resident and nurse implies long-term commitment, reciprocal relationship on a personal level and interpersonal competence of the nurses to understand each resident's needs.

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What is already known about the topic?

- Quality of nursing care is a multidimensional concept that could be described from different perspectives including the management, the professional caregivers and the care receivers and their relatives.
- The residents in nursing homes have a long-term relationship with the nurses which require a unique approach to the interpersonal aspects of nursing care.
- The care receivers are the primary source to evaluate the interpersonal factors and outcomes of care, and it is important to integrate their perspective of quality of nursing care.

What this paper adds

- This study provides a greater understanding of interpersonal factors for quality of the patient–nurse interaction in nursing homes from the residents' view.
- The study highlights dimensions in which the residents consider interpersonal aspects of care crucial for quality of care.
- Quality of care in the view of the residents means to optimize medical, physical and psychological care, to protect their integrity and to recognize their individual psychosocial needs.

1. Introduction

Globally, nursing homes are fundamental in long-term care services, and with life expectancy lengthening, the number of those who will require care in a nursing home will increase dramatically in the next 20 years (Huber et al., 2009; Statistics Norway). National quality care standards across most developed nations emphasize patient safety, excellence in care and patient satisfaction in the long-term care of older people (Du Moulin et al., 2010; Nakrem et al., 2009). Knowing when these goals have been successfully met requires determining how nursing homes quality should and can be measured. Toward this end, there have been variable efforts to determine markers of quality, and commonly accepted quality indicators in long-term care have been criticized for the narrow focus on clinical outcomes (Nakrem et al., 2009), and for not reflecting what the residents truly desire from nursing homes (Grabowski, 2010). Therefore, more research on how nursing homes quality can be understood from the residents' perspective is needed.

According to Donabedian (1980), quality of care can be divided into at least two interrelating parts: technical care, defined as the application of science and technology of health science to the management of health problems; and interpersonal processes, specifically, the psychosocial interaction between client and practitioner. Care quality can be defined as to what extent the care provided maximizes the health benefits without increasing risk, a valuation that must be shared by the patient and practitioner. Quality in the interpersonal relationship is measured by the degree of adherence to socially accepted values, which are reinforced by the ethical principles of health professions, and expectations of individual patients (Donabedian, 1980). Client–nurse interaction is the major aspect in nursing (Kim, 1987). Kim identified four sets of variables that are related to client–nurse interactions: actors (client and nurse); social context for contact; process of interaction; and client health outcomes (Kim, 1998, 1987). Care quality, and especially the patient–health worker interaction from the patient's perspective, is an essential part of the care receiver's experience that must be understood for best value in care to be realized (Donabedian and Bashshur, 2003).

Understanding quality of care from a resident perspective has been explored in earlier work by Rantz et al. (2005, 1999). They proposed a conceptual model for nursing home care from the perspectives of residents and families, and included the dimensions: features of staff, features of care, family involvement, communication, home and environment (Rantz et al., 2005, 1999). Bowers et al. (2001) interviewed 26 residents about their experiences of being a nursing home resident. The residents' descriptions of quality of care fell into three categories: good service, reciprocal relationship with caregivers, and physical comfort (Bowers et al., 2001). This confirms that expectations about nursing home service and individual variation in needs influence the experience of quality of the health service.

Outcome of nursing home care includes elements of quality of life as well as quality of care, both of which can be transformed, either positively or negatively by nursing care. Eleven quality of life domains significant to nursing home life were identified in a study by Kane (2001). These were: comfort, functional competence, autonomy, dignity, privacy, individuality, meaningful activity, relationships, enjoyment, security and spiritual well-being. Further, the domains were confirmed as related to an overall construct of quality of life (Kane et al., 2003). In an interview study with 27 residents and families focusing on quality of life indicators in long-term care, the interpersonal aspects of the nursing home environment were found to be of significant importance to the residents' quality of life, and included feelings of respect, involvement, reciprocity in relationships, and competency through technical nursing and attitudes (Robichaud et al., 2006).

Long-term residents in nursing homes have long-term relationships with the nurses, which is in contrast to many other health service settings where the relationships with the caregivers are short-term and fluctuate more. In an interview study with residents about their understanding of quality of care, a long-term relationship with the staff was perceived important to preserve their dignity, identity and integrity in care, and was foundation for quality of care (Coughlan and Ward, 2007). In a study by Brown Wilson and Davies (2009) the relationship between the resident and nurse was found to be dependent on the approach to care delivery the nurse adopted, which is described as individualized task-centred, resident-centred or relationship-centred. Outcomes of relationship-centred care were development of a shared understanding of all residents', staff's and family members' needs, and a feeling of all being included as members of the nursing home community (Brown Wilson and Davies, 2009). Furthermore, positive experiences for residents, relatives and staff created by

relationship-centred approach to care, are associated with values in The Senses Framework developed by Nolan et al. (2001), which is based on six underpinning values: security, continuity, belonging, purpose, achievement and significance (Aveyard and Davies, 2006; Nolan et al., 2001).

The interpersonal relationship in patient–nurse interactions has been found to be an essential factor in person-centred care, regarding the interpersonal skills as part of the nurses professional competence and prerequisite for person-centred processes, resulting in desired outcomes for the residents and high quality of care (McCormack and McCance, 2006). In a qualitative meta-synthesis of four studies, framed in this person-centred nursing framework, these pre-requisites were confirmed as important, but characteristics of the care environment and provision of care activities that are person-centred are critical factors (McCormack et al., 2010). The nursing home residents are frail older adults, characterized by complex needs due to several concurrent chronic conditions, and thus, dependent on advanced nursing care. Hobbs (2009) did a dimensional analysis of the concept "patient-centred care", and the central organizing perspective was that care quality is strongly connected to the patient–nurse interaction, and the nurses' skills, knowledge and competencies to alleviate the patient's vulnerabilities (Hobbs, 2009). Therefore, uncovering what individuals view as important for quality patient–nurse interactions as they live in the nursing home may help to develop a more effective person-centred care for nursing home residents.

2. Aim and objective

The aim of the present study was to explore mentally lucid residents' understanding of quality of nursing care in nursing homes. The main objective was to describe the nursing home residents' experience with direct nursing care, related to the interpersonal aspects of quality of care.

3. Method

Quality inquiry is a valuable approach when the aim is to achieve a holistic understanding of a multifaceted phenomenon in a specific context (Patton, 2002). In this study, meaning is studied as a shared meaning in the nursing home culture, recognizing that each person bring to bear the understanding held by members of the groups to which he or she belongs (Gubrium and Holstein, 2001). The long-term nursing home residents are individuals with their individual background, but they also have a shared meaning of the experience of living in a nursing home. By comparing and contrasting the individual interpretations of meaning, it could be synthesized into more general accounts.

3.1. Participants and settings

The study is part of a larger programme of research focused on multi-dimensional aspects of quality of care in Norwegian nursing homes. A purposive sample of four municipal public nursing homes in Norway with long-term care residents was included, comprising a representative sample of small-, medium- and large-sized nursing homes in both urban and rural areas. The nursing homes had mixed populations according to medical diagnosis, physical and cognitive functioning, age (ranging from 45 to 100 years old) and gender. Most residents had single rooms with en suite bathrooms, but in all nursing homes in the study there were also double rooms and shared bathrooms. Each unit, which varied in size between 8 and 35 beds, had a shared dining room in addition to the nursing home's institutional living rooms or public areas where concerts, exercise activities and festivities were arranged.

The sampling of residents to collect data in the present study, was done purposely to permit understanding of the phenomenon care quality in depth, and the aim was to have information-rich cases who could bring forward issues of central importance (Patton, 2002). Even though the population of residents in nursing homes are very frail with reduced endurance, and often have speech problems, other studies have shown that residents can successfully participate in interviews as long as these challenges are accounted for (Bergland and Kirkevold, 2006; Hauge, 2004; Wenger, 2002). The inclusion criteria were age of 65 or older, being resident of the nursing home for one month or longer, having physical and mental capability to handle the interview and ability to give informed consent to participate. Initially, 24 informants were recruited by one of the clinical nurses in the nursing home. The researcher contacted the residents consecutively, handed out the information letter and read it out loud when requested. The residents consented orally to participation and the time for each interview was determined. The informants were encouraged to ask a relative or friend to read the cover letter. Several of the informants had shown the letter to relatives, but none wanted another person to be present during the interview. Inclusion of new informants continued until the researchers felt that no new elements were emerging. Two additional residents were interviewed, but no new information was obtained.

3.2. Data collection

Data for this study were collected by in-depth interviews with the residents (Gubrium and Holstein, 2001). All interviews were conducted by one researcher. To assist the interviewer, an interview guide with open-ended questions and probes was used. The guide was reviewed by three experts for its face validity and piloted with one resident. To have an information rich description of the informants' experiences, a narrative approach was used for the interviews, encouraging the informant to freely tell about their life in the nursing home. During the interview, the interviewer repeated and summarized the expressions of the informants and asked them whether it was correct.

3.3. Data analysis

Each interview, which typically lasted for 1 h, was tape-recorded and transcribed verbatim. The analytic approach consisted of meaning coding with categorization, leading to a systematic conceptualization of the interviewees' statements (Kvale and Brinkmann, 2009). Immediately

Table 1
Participants and settings.

	NH 1 (urban, 80 bed)	NH 2 (rural, 68 bed)	NH 3 (rural, 57 bed)	NH 4 (urban, 24 bed)
Women (age)		R3 (75) R4 (89)	R9 (92) R10 (84) R11 (77) R12 (77) R13 (75) R14 (85)	R15 (88)
Men (age)	R1 (84) R2 (87)	R5 (96) R6 (82) R7 (80)	R8 (87)	

NH = nursing home; R = resident (informant).

after each interview, the interviewer took notes that described the setting and summarized the general impression of the interview. The analysis continued when all data were collected (Gubrium and Holstein, 2001). First, to get an overview of themes and a general impression of what the interviewees had expressed, the transcripts were read through while listening to the tape recording and a matrix of the first general themes was constructed. Next, meaningful entities in the transcripts were identified, and the text or expressions of the interviewees were sorted into more specific categories. An electronic tool for mind mapping (MindjetMindManager 8) was used in this process. Finally, the meaning in each category was synthesized by comparing and contrasting the content and by comparing this with existing theory and literature. To enhance rigour in the analysis, the authors of this article were all involved in the discussions about development of analytical concepts (Seale, 2007). The main author of this paper coded all interviews. Two interviews were coded separately by another researcher in the team and this was compared with the coding done by the main author. As the analysis proceeded, the whole team had meetings and discussed the abstraction into categories and subgroups.

3.4. Ethical considerations

The study was approved by the Regional Committee for Medical and Health Research Ethics. Before the interview started the informants were assured that all information would be kept confidential, participation was voluntary and refusal to participate would have no impact on their situation in the nursing home. Residents who were able to write signed the written consent, in addition to the oral consent. The care personnel in the nursing home were informed who had participated in the study so that they could give extra attention to the resident after the interview if needed.

4. Findings

Fifteen informants (Table 1), representing all four nursing homes, were included in the study, nine women, aged 75–92, and six men, aged 80–96.

The interviewed residents had views on the nursing home quality that included structural factors, caring and interpersonal aspects, and the effect these have on their quality of life in a nursing home. Findings related to structural factors such as routines and staffing, are being published elsewhere. This article focuses on findings related to interpersonal factors of direct nursing care and resident outcomes of nursing care. From the interviews three main categories in interpersonal care emerged (Table 2). The informants talked about care for and alleviation of medical, physical and psychological needs, expressed concerns about issues of integrity, and engaged in psychosocial well-being in the nursing home. In all the themes, the residents considered the nursing staff's properties, such as behaviour and values, and actions, such as prioritization, as important for quality of care. It is worth noting, though, when talking about the direct care, all informants in this study referred to nurses collectively. The term "staff", without distinguishing between different nurses with different educational level was used, and the residents carefully tried not to mention any names. Only when talking about social relationships with the nurses, a few used the first name of a specific nurse they had a closer relationship to.

4.1. Getting the basics right: quality care for, and alleviation of medical, physical and psychological needs

Within this category three sub-categories were generated: general and specialized care; health promotion and prevention of complications; and too old and sick to be prioritized; describing how quality of care is associated with interpersonal processes.

4.1.1. General and specialized care

The care itself and how the residents were cared for by the staff was one of the main topics the informants engaged in. The interactions between the residents and the nurses were mainly connected to treatment and care for

Table 2
Overview of main categories and sub-categories of resident–nurse interactions.

Care for and alleviation of medical, physical and psychological needs
General and specialized care
Health promotion and prevention of complications
Too old and sick to be prioritized?
Protecting the resident's integrity
Self-determination and dependency
Altered role from homeowner to resident
Fear of indignity and depreciation of social status
Psychosocial well-being
Balancing the need for social contact and to be alone
Preserving the social network

their medical, physical and psychological problems. The residents had many diseases and afflictions in addition to age-related functional decline. Since the age-related problems had often occurred before admission to the nursing home and had progressed over time, the residents had coped previously with it in their own way. However, most residents had experienced serious health problems that required advanced treatment and varying needs through a day that made access to 24-h service a prerequisite. The residents emphasized being safe, having access to prompt emergency care, and having their basic needs met, to be satisfied with the nursing home service. Most residents thought that the medical treatment for their current situation was as good as it could be. They said that the health service they received, which included basic nursing care and physician service, was excellent:

> Well yes, you see – they do the best they can for you. They work hard all day long. They help you right away... if you need it. (R11)

The residents referred to the staff as kind, pleasant and clever. They expressed that they trusted the staff and felt they were given the most competent care available at the moment according to their needs. Most residents were grateful that some of their problems were taken seriously and that they were given adequate treatment, for instance careful follow-ups of blood status, medication side effects and symptoms of infection.

Not all the residents were focused on their physical needs and some perceived their physical state as being outside their control or responsibility. One resident (R3) who had lived in the same nursing home for years had a distanced relation to her body. She gave the nurses full control and care of her physical needs. When asked what she felt about her problems with leakage from the urostomia and skin breakdown, she answered that it was the nurses that worried most, and she did not really care. Still, she observed that some nurses were particular careful when washing and handling her; it was important to avoid scratching her skin, she explained.

However, many of the residents were uncertain about the nursing home's ability to give adequate care in case their functional level declined or they became more ill. One of the interviewees expressed that nursing home was "a lovely place to be, as long as you are healthy" (R4). Another resident said that he had given up trying to get adequate pain alleviation. He thought that the staff did not offer other treatment because they would not listen to him or no other treatment was available. He expressed ambiguous feelings about his life: "It couldn't be better - If only I could be better in my foot, I could walk around a bit alone" (R8). Another resident was severely undernourished and anaemic before a nurse, by coincidence she said, noticed that she had a health problem. Many residents expressed that they feared becoming more helpless than now and hoped that the dying process would go quickly.

4.1.2. Health promotion and prevention of complications

Efforts from the nursing staff to promote their health or, at least, prevent further complications following their chronic clinical condition were perceived as essential. Good health was related to being active, eating well, having the ability to get up in the morning without being helped, having no pain, and having a good sense of humour or good mood. Health decline meant a reduction in normal functioning or a lessened ability to participate in daily life activities: "You just can't get out of bed" (R4). Others described failed health as "pure misery" or "not managing anything" (R2). Many of the residents perceived that they had good health despite of suffering from many diseases. One extraordinary example was a man with paraplegia after a spinal nerve lesion in the neck who said that his health was "darn good" (R6). It seemed that the residents differentiated between health and disease as two different aspects. They credited their strength or hereditary characteristics if they had good health and "bad fortune" if they had a disease that required long-term care.

The residents saw the prevention of a decline in functioning as very important, and had hoped more active care was offered by the nurses in the nursing home. They missed more physical therapy, physician attention and systematic interventions to avoid falls. However, the residents were aware that the diseases they had could not be treated to the point of full remission, and some of their health problems had to be coped with, as they could not be cured. "You just have to live with it" was a typical expression on dealing with such a situation. Many talked about being prepared to die or that they already were living beyond expected lifetime.

4.1.3. Too old and sick to be prioritized?

During the interviews, it appeared that some of the interviewees perceived themselves as being of less worth. They thought that older nursing home residents received less attention, not only in the health service generally, but that this was reflected in the attitudes of the nursing staff. One resident expressed a feeling of being neglected, since the nurses did not response to the alarm bell. The residents feared being ignored or that their problems would not be noticed if they did not express themselves verbally:

> It doesn't work like it should. It takes too long. Once I watched and it took over an hour before someone came. So they (other residents) lie there and holler instead. You're supposed to use the alarm but they've found out that it works if they holler. (R7)

It was common for the residents to not want to be perceived as troublesome, and they were concerned at being burdens to the nurses. With the shortage of nurses they often chose not to ask for extra help and had lowered their expectations. For instance, one resident said that she had reduced her activity after she moved into the nursing home because she did not want to ask for help (R4). They thought that it was not possible to have these needs met in the nursing home because of inadequate staffing or lack of prioritization.

The residents perceived that access to optimal care was outside their reach. Several residents thought that, for instance, surgical treatment was not offered to older people because it was too risky. Still, most residents shared

a hope that surgery was an option if there was any possibility that their afflictions could be relieved. Other residents did not want more care, even when the health personnel offered it. A resident who had severely injured her knee in a fall was offered knee prosthesis, but she said that she did not dare to be operated. Another resident explained that he was offered a shower once a week, but he refused because he became exhausted and dizzy:

> I can't shower anymore. Just have to wash myself here (in the room). I did it (shower) at first but just had to give up. I would just fall, you know. It was my decision; I just said I couldn't do it. Just have to get washed, change clothes and such. (R2)

It was important to the residents that they felt in control of their own life and could participate in treatment decisions.

4.2. Protecting the resident's integrity: the foundation for quality care

In this category, three sub-categories involving interpersonal aspects of care quality emerged: self-determination and dependency; the altered role from homeowner to resident; and fear of indignity and depreciation of social status. The residents expressed that they appreciated that nurses had special attention to these aspects and compensated for the threat to their integrity.

4.2.1. Self-determination and dependency

To be self-reliant in daily activities was important for the resident's feeling of independence. Many expressed that being able to take care of oneself such as wash and dress without nurse assistance meant a better life. To be independent, to feel free or to have the possibility to live in your own way, were expressions they used:

> I decide over my own schedule, I'm independent and that is a good feeling. I feel free, and I am too. But of course I am dependent. And that is a feeling of safety... I am safe, you know. My life is so good... I make my own decisions. (R15)

Control over daily issues such as being able to decide over the diurnal rhythm, whether to participate in social activities, what to eat for dinner or how to furnish a private room with personal belongings made them feel more self-determinant. Arrangements that reduced barriers to travel or to move freely in and outside the nursing home were appreciated and increased the feeling of independence. An example was when a resident (R8), who was dependent on intermittent catheterization of the bladder twice a day, got an indwelling catheter for a few days so that he could visit his children who lived a several day journey away. He proudly said that he had been able to complete the journey.

Accepting dependency of the nurses was part of a trustful ceding of the responsibility for their health. However, this dependency seemed to displace power and control over the day and made them dependent on nursing home routines. A male resident (R7), who recently had moved into the nursing home, said that it had not been his decision to move. He constantly underpinned that he was forced to stay in the nursing home and that he wanted to go home. He had fallen several times at home and he agreed that it was not safe for him to live home alone. Independence held such an important place in his life that living in a nursing home threatened his dignity.

4.2.2. Altered role from homeowner to resident

Moving into a nursing home had been, for most residents, a role change process from an independent person to a user of institutional services. Nursing home service offers overall service that includes accommodation, household and health care. This had relieved the residents' responsibility for a house and taking care of their health, but the new role as a nursing home resident implied a change in behaviour. The changed role was particularly visible in the altered routine with visitors. When living at home, the residents were hosts, which meant they decided who to welcome and what to serve from their own kitchen. After moving into the nursing home, they no longer had a kitchen to serve from or their own living room to be with their guests in. They perceived the nursing staff as host and themselves in an unclear role as guests in their own home. Though they spoke about this altered role with sadness, most of them had accepted it as part of the general functional loss that caused them to move into the nursing home.

Another major difference between living at home and in an institution was the amount of control they had over the physical environment. Their private rooms could be locked, but residents kept the doors unlocked in case they needed the nurses to assist them. The nurses had easy access to their rooms and most nurses knocked on the door before entering. However, this meant that other residents could also enter their room, and this concerned them. One of the interviewed women (R10) said that after an episode where a confused male resident had come into her room late at night, she was afraid to go to sleep until she knew this man had gone to bed. The residents wanted the staff to look after the confused, wandering residents, so that they could feel safer.

4.2.3. Fear of indignity and depreciation of social status

The residents expressed that their dependence on assistance was a strain. They tried to take care of as much as possible by themselves. A feeling of defeat when they had to call the nurse for help was reported by the interviewees. However, none related this reluctance to ask for help to bad experiences with the care provided. On the contrary, the care they received was excellent by their evaluation. They attributed the sad feeling of defeat to loss of function, aging and frailty, and longed to be younger and in better shape. One woman said that she felt that she was no longer part of society when she moved to the nursing home:

> I stay in contact with friends and family but less and less often. When you come here, it seems like there isn't more. It wasn't like that when I was home and cooked and had them over. (R14)

The feeling of being a burden to society, due to their extensive need for health care, was implicit in all interviews. As a result of this feeling, most residents were very grateful and eager to express how lucky and satisfied they were with the nursing home and nursing staff.

The residents had strategies that helped them to maintain dignity. Strategies such as to take one day at a time and not reflecting on future problems, retaining good mood, and appreciating the life they had lived, worked as a buffer against feeling less valuable as a person. Expressions such as "fortunately, I have good eyes and ears", "I'm not in any pain" and "at least I haven't had a stroke" were examples of coping with functional loss. The female residents said that it was important for their feeling of dignity to maintain their appearance, to style the hair or buying fine clothes. It was appreciated when the nurses could support their positive features instead of merely focus on their illnesses and problems.

4.3. Building relationships that enhance psychosocial well-being: a key issue of quality of care

The third category constituted important areas in the patient–nurse relationship pertinent to psychosocial well-being, focusing on the role of the nursing staff. Subcategories were: balancing the need for social contact and to be alone; and preserving the social network.

4.3.1. Balancing the need for social contact and to be alone

The residents had much contact with a wide range of staff, such as registered nurses, licensed practical nurses, assistants, the physician, and activity coordinators during the day since all residents needed help in their daily activities. To have someone to talk to during the day was considered important for the quality of life. Most residents emphasized a close relationship to the nurses as a key factor for a good day. Few, however, singled out a specific nurse as special and the nursing staff was for most residents seen as "all the same". Many of the residents, though, felt that the staff genuinely cared for them on a personal level, which they showed by giving them an occasional hug or speaking with them in a friendly manner.

A good conversation was considered one that created a good atmosphere where the nurse talked about both her life and the resident's interests. This reciprocal exchange of information was especially important in the rural nursing homes. It strengthened the residents' feeling of being a member of the local community. In NH3 and NH4 the staff would sit in the shared living room for their coffee breaks and led the conversation with the residents. This was much appreciated by the interviewees in these nursing homes and motivated them to join in.

Even though most residents felt they had a good relationship with the nurses, some residents were doubtful about what the relationship could offer them. Two of the informants (R7 and R15) mentioned that the nurses were too young to understand older people and expressed that the young nurses had interests that they did not care about. Further, the only time they had the opportunity to talk at length was during morning care which often was characterized by haste. Thus, the residents felt that nurses could not fulfil the needs for a close relationship in the same way as friends or family could.

The residents had individual needs regarding close relationships in the nursing home community; depending on the amount of contact they had with their family and how socially active they had been before moving into the nursing home. The balance of their need to socialize and their need for time alone was regulated by the residents themselves by choosing how much time they spent in the communal rooms and their private rooms. However, an ambiguity in psychosocial well-being emerged as they said that they missed their former social environment and that appropriate, reciprocal social relationships could not be found in the nursing home. It was difficult to find someone that had similar interests, and it was problematic to relate to residents with cognitive deficits or severe disability. One resident (R7) expressed a feeling of being excluded from the nursing home community and said that there were "cliques" of residents that did not want to talk to him. The residents who made an effort to create a pleasant community by spending time in the communal rooms, trying to accept the diversity of the other residents and chatting with everyone seemed to cope better with the ambiguous social environment.

4.3.2. Preserving the social network

Since the residents were somewhat ambivalent toward the nursing home's ability to fulfil their psychosocial needs, it was important for them to preserve their former social network. The residents emphasized the importance of their family or friends feeling welcome in the nursing home as visitors. The residents noted that when the nurses greeted their relatives on arrival and offered them a seat and a cup of coffee, they felt their guests were welcome. In the rural nursing homes, the visitors were familiar with the nurses and the other residents, and they walked in and out of the nursing home with more ease than in the city nursing homes. Assistance to keep in touch with their family, for instance getting help to phone them was one way of upholding a social network for those with family and friends far away from the nursing home.

Many residents had experienced the loss of close family members or friends, and this made them feel lonely. Lack of social relationships outside the institution made them more dependent on the nursing home community, and especially dependent on the nursing staff. It was important that the nurses had information about their family because this was a common topic in daily conversation. During the interviews, all the residents talked about their family and their former life and were eager to show photos they had on their walls. The residents were proud to share that they were grandparents or great-grandparents. One resident explained that having a family and looking at family photos reminded her that she still had so much to live for (R12).

5. Discussion

The present study highlights areas in which, from the residents' perspective, the interpersonal aspects have a major influence on nursing care quality. The residents

expressed that it was important for them that the nursing staff cared for them so that their problems and afflictions were kept on a minimum level and further functional decline was prevented. The residents talked about caring relationships in which their integrity was protected, and put great emphasis on support from the nursing staff to uphold their social relationships.

It is worth noting that the residents in the present study felt that many areas of nursing home care of importance to the residents depended on the direct efforts of the nurses, such as receiving care with acknowledgment for remaining functions, being treated with respect or simply having someone to talk with. The dependency of the nursing staff was generally accepted, but it created an extra vulnerability. Power and control in everyday situations were placed on the nurses in their interactions with the residents. The fact that the residents during the interviews were reluctant to evaluate individual nurses could be attributed to their dependency of the care givers and asymmetry in power. The residents in our study expressed that having decision-making power was important in their everyday life, and thus important factors for care quality. Other research has demonstrated that the nurses have great impact on the residents' experience of ''being someone'' or contrarily ''being nobody'' in the way they include or exclude the residents in the nursing actions (Westin and Danielson, 2007). In relationship-centred care, the interactions between the parties in care are regarded as foundation of any therapeutic or healing activity (Aveyard and Davies, 2006). However, according to Nolan et al. (2004), all participants in the interaction need to experience reciprocal interpersonal relationships that promote genuinely empowering if quality care is to result.

It could be argued that the possibility of creating such relationships may be limited, since the residents in our study perceived the nurses as busy and felt that they could not expect to receive more attention from the nurses. Some of the residents were even uncertain about what relationships with staff could offer them. The nurses' skills and ability to connect with, and know each resident are important factors for successful individually adjusted care (McCormack and McCance, 2006). The caregivers' commitment to the relationship with older people is a deep human feeling that is fundamental in long-term care, and should be promoted to enhance quality of care (Haggstrom et al., 2010). Bowers et al. (2000) found in their study that time and stability in the nurse staff was crucial for assessing the residents' individual needs, which is necessary to give adequate care. Quality of care is enhanced not only by more time in care, but also by continuously adjusting to the residents' needs and hopes in caring interactions (McCormack, 2003; Perry, 2009).

The findings in the present study underpin the nurses' responsibility to be involved in creating social environments that support the quality of life for the residents. The residents appreciated that the nurses showed through behaviour that both residents and staff are part of the nursing home community almost like a family, and shared reciprocal information about themselves and their family. Residents in nursing homes often report loneliness as a problem (Slettebo, 2008), and there is often little communication between residents (Hauge and Heggen, 2008). The formation of new relationships may be inhibited since few of the residents have the ability to participate in meaningful conversations (Bergland and Kirkevold, 2008). Consequently, the residents become more dependent on the nursing staff, not only for clinical care, but also for their psychosocial wellbeing. It is important, though, that the residents' social needs are assessed and that the nurses are sensitive to the preferred involvement from the nurses (Bergland and Kirkevold, 2005). It has also been found that nurses, residents and family members define close nurse–resident relationship differently (McGilton and Boscart, 2007). Nurses focused on emotional connectedness, residents based their definition on attitudes and behaviour of the caregiver, and family determined the closeness of relationships by the positive effect it had on well-being. This has implications for how quality of care is defined and measured (McGilton and Boscart, 2007).

The many functions of the nursing home contribute to the complexity of the service. The nursing home is the residents' home and place to live, their social environment where they experience most of their social life and the place where health care service is provided. The diversity of the residents' needs, varying from palliative care to social stimulation, adds complexity to nursing care. Becoming very frail or suffering from dementia could put the resident's perception of being treated with dignity at risk, because the resident would have difficulties in maintaining self-respect and identity (Pleschberger, 2007). It is important to acknowledge risk of low care quality for the most vulnerable residents, and to take this into consideration when it comes to clinical prioritizations in nursing homes (Slettebo et al., 2010). The notion of centredness itself, conceptualized as patient-centredness, person-centredness or relationship-centredness, reflects a movement in health care away from the narrower biomedical view, in favour of a broader view, which involves increasing the social, psychological, cultural and ethical sensitivities of human encounters in health care (Hughes et al., 2008). Furthermore, the nursing home's organization, staffing and organizational culture influence the patient–nurse interaction (Brown Wilson, 2009). Hence, integrated research on all factors that impact the delivery of care is needed to understand how to improve interpersonal relationships and quality of care in nursing homes.

Some limitations of this study should be addressed. One threat to the credibility might be that the informants could have perceived the interviewer, who is a nurse, as a representative of the health care and therefore be reluctant to criticize the nursing home quality. Another element is that the authors' presuppositions may have limited the possibility to understand the cultural assumption of the interviewees (Rubin and Rubin, 2005). However, the authors discussed how this might influence the interpretation, thus enhancing the credibility of the findings.

Finally, transferability might be limited due to the relatively small sample consisting of only mentally lucid residents from four nursing homes. Even so, mentally lucid residents may hold the common voice of nursing home residents. Therefore, the findings in this study may contribute to understanding the experience of other residents in nursing homes, taking into account their individual and contextual circumstances (Kvale and Brinkmann, 2009).

6. Conclusions

Quality nursing care in nursing home implies a balanced, individual approach to medical, physical and psychosocial care, including interpersonal aspects of care. The residents are often frail and vulnerable and their dependence on the staff is evident. Therefore, it is particularly important to protect each resident's integrity by recognizing the resident as an individual with individual needs. However, to assess the individual needs, the nurses must put efforts into knowing each resident. The interpersonal relationship between resident and nurse implies long-term commitment, reciprocal relationship on a personal level and understanding of each resident's needs.

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