Becoming part of an upwards spiral: Meanings of being person-centred in nursing homes

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Abstract

Introduction: Previous research suggests that person-centred care is positive for people living in nursing homes, but less is known on what motivates people working in nursing homes to be person-centred. Previous research has focused on person-centred care in relation to people in need of care, which may lead to a risk of viewing person-centred care as a means to achieve quality of care, and not as a means in itself. Therefore, this study aimed to illuminate meanings of being person-centred as narrated by people working in nursing homes.

Methods: A total of 23 persons working in a nursing home in rural Australia participated in group and individual interviews, conducted and interpreted in respect to a phenomenological hermeneutic approach.

Results: The thematic structure as emerging from structural analyses of the text indicated that being person-centred involved a joint effort to think differently on what you do and why you do it interpreted as: Doing what you know and feel is the right thing to do, Being a person with and for another person, and Striving to do and be better together. The comprehensive understanding of these findings was that being person-centred means becoming part of an upwards spiral of doing person-centred actions and being person-centred to become even more person-centred and to feel a sense of belonging to a person-centred culture.

Conclusions: Denoting the importance of being more of a person in one's professional role, this study highlights health aspects of being person-centred from the perspective of people working in nursing homes, and complements previous research that describes the impact of person-centred care on people in need of care. The findings could be applied to facilitate person-centred care in nursing home contexts, and to develop prevention strategies to diminish negative impacts on person-centred doing, being, becoming and belonging.

Keywords
health, long-term care, occupation, person-centred care, qualitative research
1 | INTRODUCTION

Person-centred care in nursing homes was developed by Tom Kitwood (1997), who saw the need for a response to healthcare organisations that treated people with dementia as living dead, or empty shells. Making people realise that people with dementia are more than bodies affected by a disease that makes the person disappear, Kitwood (1997) therefore developed person-centred dementia care with focus on personhood in the 1990s. According to Kitwood (1997), personhood concerns how human beings relate to each other in the context of different social relationships and institutional arrangements (Kitwood, 1997). Since then, definitions on person-centred care have developed, to incorporate relationships, both within the care context and beyond, extending to the social networks of the people in need of care (Edvardsson et al., 2008; Ekman et al., 2011; Slater, 2006). Nevertheless, in the scientific literature, person-centred care has mainly been used as a concept to provide preconditions for care that supports the personhood of the person in need of care (McCormack et al., 2012), and to improve the quality of care (Brownie & Nancarrow, 2013). As suggested by Kadri et al., 2018, there is, however, also a need for people working with care to be acknowledged as valued persons in the care process.

According to Edvardsson et al. (2008) and McCormack et al. (2010), working in a person-centred way means meeting each person's needs and personalise the care and environment by prioritising human interaction and shared decision-making (Edvardsson et al., 2008; McCormack et al., 2010). Other literature delineates people working in health care as responsible for facilitating trustful relationships between them and the person in need of care (Naldemirci et al., 2018). Although important, this notion of person-centred care as a moral duty to care for another person risks to put focus on person-centred care as a means to an end, rather than being a goal in itself. For instance, people working in highly slimmed nursing home organisations may face the risk of being treated as executors of standardised care procedures (Ronch, 2004), and of feeling de-personalised and undervalued (Kadri et al., 2018). In addition, people who work in nursing homes may experience both physical and emotional challenges associated with their jobs (McGilton et al., 2016), which may result in them choosing to change jobs even if they, in general, may be satisfied with their work. Reasons for this may be that they are less satisfied with their working conditions, which may include heavy workloads, lack of appreciation and recognition, and lack of the resources necessary to provide quality care (Chamberlain et al., 2016; Choi & Johantgen, 2012; Squires et al., 2015). As a consequence, many nursing homes struggle with high turnover rates among staff due to organisational factors, such as staffing levels and work culture (Karantzas et al., 2012; Zhang et al., 2019).

According to previous research, opportunities to work in a person-centred way in nursing homes are positively associated with high job satisfaction (Vassbø et al., 2019) (Choi et al., 2021), and thriving at work (Vassbø et al., 2019). In addition to this, Tellis-Nayak (2007) has visualised the importance of a person-centred workplace that allows the person behind the professional role to emerge, making use of both professional and personal experiences, skills and stories (Tellis-Nayak, 2007). This all adds up to a notion of person-centred care as beneficial, not only for people in need of care, but for people providing care too. Yet, to understand the relationships...
between job satisfaction, thriving at work and person-centred care on a deeper level, there is a need for explorations of reasons for people working in nursing homes to be person-centred in relation to the people living there.

2 | AIM

This study aimed to illuminate meanings of being person-centred as narrated by people working in nursing homes.

3 | MATERIALS AND METHODS

3.1 | Study design

A qualitative design with a phenomenological hermeneutic approach inspired by Ricoeur’s interpretation theory (Ricoeur, 1976) was applied to allow for the sharing and interpretations of narratives on meanings of lived experience. The structured methodology developed by Lindseth and Norberg (2004) was used for analytical purposes, which meant that the narratives were interpreted in three consecutive phases: naïve understanding, structural analyses and comprehensive understanding.

3.2 | Context, setting and participants

Participants were recruited from an Australian nursing home situated in a small rural town with approximately 1500 inhabitants. Australian nursing homes are encouraged to provide personal care to the persons living there (Grove, 2019), and the persons recruited to this study had participated in a study that aimed to promote person-centred care and facilitate thriving (Edvardsson et al., 2017). The nursing home included in this study had 50 beds, nursing home staff were available 24h for the persons living there, and allied health professionals were available for care and rehabilitation when needed. Most of the persons living in the nursing home were women (about 70%), dependent in personal activities of daily living (about 80 per cent) and lived with cognitive impairment (about 60%). A total of 24 persons working in the nursing home were invited to participate in the study through the workforce and service development manager at the facility. All but one person accepted the invitation and participated in group interviews and/or individual interviews as shown in Table 1. A majority of the participants were women, aged between 24 and 63 years of age, and there was a mix of enrolled nurses, registered nurses, allied health professionals and people with other work roles that cannot be revealed due to the confidentiality of participants. There were no direct inclusion or exclusion criteria, but the participants had to be able to narrate their experiences in English.

3.3 | Data collection

The data collection was conducted in three consecutive steps between September 2017 and January 2018. First, an individual pilot interview was conducted to test the narrative method. Second, group interviews were conducted with 16 persons (including the person who participated in the pilot interview), to identify traces of meaning to generate a list of meanings for deeper investigation in individual interviews. Third, individual interviews were conducted with 11 persons (some of them had participated in the group interviews, see Table 1) to deepen the understanding of the traces of meaning that had emerged during the group interviews. Between each interview, the first and third authors discussed traces of meaning, to deepen the understanding through the forthcoming interviews.

The interviews were conducted by the first and third authors at the nursing home where the participants worked. One interview had to be conducted over the telephone with a person who was on sick leave. Drawing upon the participants’ shared familiarity with person-centred care, the participants were asked to narrate their

| TABLE 1 | Participant characteristics |
|---|---|---|---|
| | Group interviews (n = 16) | Individual interviews (n = 12)* | All participants (n = 23)** |
| Age in years, median (range) | 53.5 (24–63) | 54 (24–63) | 54 (24–63) |
| Women, n (%) | 16 (100) | 9 (75) | 20 (87) |
| Employed as, n (%) | | | |
| Enrolled nurse | 3 (19) | 4 (33) | 6 (26) |
| Registered nurse | 7 (44) | 2 (17) | 8 (35) |
| Allied health | 4 (25) | 3 (25) | 5 (22) |
| Other | 2 (12) | 3 (25) | 4 (17) |
| Years of work experience in aged care, median (range) | 14.5 (1–42) | 9 (1–30) | 10 (1–42) |

*Including one pilot interview; **Five of the participants participated in both group and individual interview.
experiences of person-centred care, and what it meant for them to be person-centred. The interviewers encouraged the participants to talk freely, and only asked questions when something needed to be clarified or when they wanted to develop the participant’s story. Questions that were asked to encourage further narration were as follows: ‘What happened when you did that?’ and ‘How did that make you feel?’. The group interviews lasted between 24 and 32 min, and the individual interviews lasted between 14 and 34 minutes. All interviews were recorded digitally, field notes were taken, and all recordings were transcribed to facilitate interpretation of meanings.

3.4 | Data management

Access to data is restricted, and in line with ethics on participant confidentiality, the data generated and interpreted during the study are not publicly available. De-identified are available upon reasonable request to enable review and will be stored for 10 years at La Trobe University to enable review. A confidentiality assessment will be performed at each individual request, and permission from La Trobe University, School and Nursing and Midwifery, has to be obtained before data can be accessed.

3.5 | Data analysis

With Ricoeur’s (1976) phenomenological hermeneutics as the methodological foundation, field notes and data from all the interviews (pilot, group and individual) were interpreted in line with what Ricoeur (1976) described as the hermeneutical circle, applied to Lindseth and Norberg’s (2004) methodological steps. This meant that the interpretation moved back and forth between meaning units, the text as a whole, and preliminary themes through three methodological steps: naïve reading, structural analyses and a comprehensive understanding (Lindseth & Norberg, 2004).

Starting with naïve reading, the first and third authors listened to all the interviews and read the field notes and transcripts without differentiating between whether they were group interviews or individual interviews. The goal with this step was to formulate a joint articulation of their naïve understanding of the text. Then, the articulation of the meanings identified through the naïve reading was used by the first author as a conjecture for the forthcoming structural analyses that sought to validate or invalidate the naïve understandings (Lindseth & Norberg, 2004) to reveal the meanings of the studied phenomenon. This meant that the first author formulated questions to the text based on the naïve understanding, used to identify meaning units in four separate structural analyses with the aim to unearth the thematic structure of the text through articulating themes relating to the naïve understanding. Meaning units were gathered, condensed and interpreted into preliminary themes that illuminated the questions. The interpretations and preliminary themes from the structural analyses were then discussed among all three authors to make sure that they conveyed the content and indicative meaning of the text and that the interpretations stayed closed to the data. Lastly, all data were read through once more, through the lens of the authors’ pre-understanding, the naïve understanding, the formulated themes and appropriate literature in mind. Different literature was discussed among the authors, to reach a final comprehensive understanding that recontextualised the narratives to deepen the understanding of the meaning of the themes. Incongruities were discussed among the authors, until a final comprehensive understanding was formulated in relation to Ann Wilcock’s (2006) framework on an occupational perspective of health. The choice of framework was inductive, and based on the interpretations of the participants’ narratives on person-centredness as a health-promoting occupation, understood in relation to the concepts doing, being, becoming and belonging.

3.6 | Ethical considerations

The University Human Ethics Committee at La Trobe University approved the study (16–002). In accordance with this approval, all participants received a letter stating the purpose and methods of the study, that participation was voluntary and that their contributions would be kept confidential and unidentifiable in all reporting of the findings. All participants also signed an informed consent form before the data collection started. One participant chose not to participate after the group interview, and all data from that participant were excluded from the analysis and all personal data from that applicant has been destroyed. All participants gave permission to use their anonymised data for publication purposes.

4 | RESULTS

4.1 | Naïve understanding

The naïve understanding of the meanings of being person-centred in a nursing home context was that it means striving to merge the professional and personal and making a difference. First, participants described that person-centred doing meant being able to make a difference to someone else’s life, doing what really mattered to the person, for example by pushing themselves above and beyond what was considered routine practice. Second, person-centred being appeared to involve being part of a creative and person-centred culture, described as a place where participants experienced being safe to go beyond standardised professional practice and engage with the older persons on a more personal level. Third, person-centred doing and being involved doing things that made the participants feel competent as well as important for the older people, their relatives as well as for colleagues, which facilitated feelings of becoming proud of one’s work and oneself, and a sense of belonging to a person-centred culture.
4.2  |  Structural analysis

The structural analysis resulted in three interrelated themes: Doing what you know and feel is the right thing to do, Being a person with and for another person, and Striving to do and be better together. These themes are described in detail below, supported by quotations from the participants. All names used to put the quotations into context are fictional.

4.3  |  Doing what you know and feel is the right thing to do

This theme describes meanings of being person-centred in terms of having a sense that you do what really matters for another person through applying both professional and personal understandings of what is the right thing to do. Professional understanding was narrated as knowledge about the other person’s healthcare needs, whereas personal understanding was narrated as knowledge about psychological, emotional and psychosocial needs. Merging the professional and personal understandings of the person in need of care meant getting a better outcome than through usual care, by applying a deeper understanding of what really mattered to them. This is illustrated by a quotation of Frida’s (allied health) answer to the question on what happened when she was person-centred:

‘Person-centred, you’re getting a better outcome. Because otherwise you may be thinking that that person is being difficult or challenging. And then when you hear about their story. And I think that you get a better outcome with that, because they love it, because they then work with me’.

Doing what you know and feel is the right thing also involved wanting to provide more than the mere clinical, and then practicing this willingness through doing meaningful activities with and for another person. Striving to engage in activities that were perceived as the right thing to do gave a sense of purpose, and contributed to a sense of professional as well as personal achievement through making a difference to someone else’s life. Elna who was employed as an enrolled nurse described how this sometimes meant going above and beyond descriptions for routine practice and see the person before doing routine tasks:

‘There is so much more that you can do for this person right now. And then I actually have to say to my partner “you know, I hope you don’t mind, we’ve done this, we’ve done that, we’ve done the protocol, what’s on our paper, but I just need to do other things.”

4.4  |  Being a person with and for another person

Staying true to what was distinctive about oneself, being a person with and for another person meant making conscious decisions to follow one’s attitude or ethos of being willing to serve. Being person-centred in this sense meant making oneself available for other people, which involved a sense of satisfaction and fulfilment through being acknowledged for what one is. Answering the question what being person-centred made her feel, Maria said:

‘They may not remember your face, but they do know your voice. And if you can calm them, sit with them, sometimes just holding their hands, that’s what they need. Sing with them. Hum with them. I dance. You know, and they smile. Just that smile, to me is a lot. It means a lot to me.’

Transcending professional boundaries and roles, being a person with and for another person also meant striving towards people living, working and visiting the nursing home becoming more like equal human beings who shared stories, knowledge and expertise. This could be done through conversations that transcend professional expertise and when being a person with and for another person, professional competence or skills went to the background, and personal qualities came more to the foreground in the sharing of moments and mere co-existence. Being able to prioritise one’s time and attention to be with another person and listen to their stories, was narrated as a driver to connect with other people, and it contributed to a sense of fulfilment by taking a step further in a relationship that was valued by both parties. This was described by the allied health professional Lucy who told a story about the importance to feel connected:

‘I think that generally here, if someone’s around, you look up and you give that acknowledgement of the person. And even if you don’t have the amount of time to do everything, but a simple acknowledgement and a smile, makes the biggest difference... It only takes a second but I feel that everybody here makes that effort. So, we’re very lucky here. And yeah, it only takes two seconds but it can really, that small interaction can really have somebody feel more connected to where they are’.

4.5  |  Striving to do and be better together

This theme illustrates the narrations of being person-centred as a joint effort to think differently on what you do and why you do it. Even if completing tasks were sometimes perceived as the easiest thing to do, a collective effort to strive for improvement served as encouragement to even better oneself, going the extra mile and thinking about what else one could do with and for another person right now, be it a person in need of care, a relative or a colleague. This was narrated by the registered nurse Sandra as.

‘We do strive for better and that there is a support and there is a desire to want to do more. Not everywhere has that desire’.
Although stressful in some situations, taking the extra time to meet someone else’s needs was narrated as being worth it in the long run creating a sense of belonging to a group that takes care of each other and pushes each other to reach even further. Serving as a reminder of who one is as a person and why one chose to work in the aged care sector in the first place, a collective spirit or culture of constant improvement presents a way to fulfill oneself as persons as well as professionals through continuous reflection. Understood as a way of creating a norm of person-centred doing and being, Marge, whose role cannot be revealed due to confidentiality, described the strive to do and be better as an encouragement and reminder for everyone at the workplace:

‘I’ve noticed the difference in there, it’s pretty easy to go in there and see a person in his chair and think I need to move that, and you just move it...but then there’s the going up to the resident and saying “I just need to move your chair. I’m going to move your chair is that ok? And I’m gonna pop it over here”... “Here we go let’s do it”, so there’s just, that sort of, you know...it’s I think, you know, when it’s task oriented, it’s it can be very, “we just need to get these things done”...but the stopping and the thinking of the resident...and if people see other people doing it, that’s what becomes the norm’

5 | COMPREHENSIVE UNDERSTANDING AND DISCUSSION

The aim of this study was to illuminate meanings of being person-centred for people working in nursing homes. These meanings are expressed in the themes: Doing what you know and feel is the right thing to do, Being a person with and for another person, and Striving to do and be better together. The comprehensive understanding of these meanings is interpreted here as becoming part of an upwards spiral which implies a collective effort to strive to integrate what you do with who you are, to become more person-centred and to belong to a person-centred culture. Becoming part of an upwards spiral can be understood from the occupational scientist Ann Wilcock’s (2006) framework on an occupational perspective of health. In her framework, occupation encompasses all the things people do to occupy themselves (work, play or daily living tasks) and it is viewed as strongly connected to health and wellbeing. Our interpretation of the findings in relation to this framework is that the meaning of being person-centred in a nursing home involves a positive health-promoting movement, or upwards spiral, of doing person-centred actions and being person-centred to become even more person-centred to feel a sense of belonging to a person-centred culture. According to Wilcock (2006), becoming means to grow and aim for one’s highest potential and best possible outcomes. Interpreted in relation to this, the narratives in this study illuminate meanings of being person-centred in terms of becoming part of an upwards spiral towards a person-centred culture through individual and collective reflection over what one does and who one is. This, in turn, was interpreted as a joint development and strive towards doing and being better together to feel a sense of belonging to other people, be it colleagues or people in need of nursing home care.

The doing aspect of being person-centred refer to what Wilcock (2006) describes as doing things that are not necessarily purposeful or organised, but can be engaging in that they give a sense of purpose or meaning Wilcock (2006). Although not semantically not referring to being person-centred, the participants’ narratives on doing what they knew and felt was the right thing to do was thus interpreted as a meaning of being person-centred for the participants. The meaning of being person-centred, in this sense, thus expands beyond concrete and contextual actions, incorporating all the things people do to make a difference to someone else’s life and to be a good person. In relation to Wilcock’s (2006) definition of being as how people feel about what they do and how their doing defines who they are, the participants’ narratives visualise the meaning of being person-centred as being a person together with and for another person. Narrated as an existential dimension of care, being person-centred was experienced as fulfilling both professional goals and a human need to exist with and for another person. This is in line with Wilcock’s (2006) description of belonging as a connectedness between people as they do what they need to do to become who they want to be and being faithful to who they are (2006). The participants described how a focus on being person-centred had created a collective strive for improvement and desire to belong to a person-centred culture that enabled personal as well as professional fulfilment. Belonging to a person-centred culture also created a value base that brought the people working in and the people living in the nursing home together, and facilitated a sense of connectedness and belonging to a larger whole.

Interpreted in relation to previous research, it is important to attend to negative catalysts that might inhibit health realisation through person-centred doing and being, such as stress and heavy workloads that may introduce a downwards spiral in organisations that do not allow staff to do, be, become and belong to a person-centred culture as described in the present study. Backman et al. (2016), and Carlström and Ekman (2012) have both emphasised the importance of leadership and culture for implementation of person-centred care (Backman et al., 2016; Carlström & Ekman, 2012), but little is still known about development of predictors to a person-centred culture, and how a person-centred culture could deteriorate and disappear. Already in 2010, McCormack et al. described both negative and positive catalysts for the development and maintenance of person-centred care, with focus on the care environment (McCormack et al., 2010). However, more research is needed on what could enable the culture change that is required to fully implement person-centred care, without allowing it to vanish with time.

Sundler et al. (2020) recently described the importance of person-centred communication in terms of making encounters personalised, showing interest in the other person and attending to what they find meaningful. They also highlight the recognition
of the older person and equality of the relationship as success factors for person-centred communication (Sundler et al., 2020). This is supported by the present findings that suggest that being person-centred in a nursing home seems to involve both the creation and recreation of oneself as a professional that is respected for both who one is and what one does. What the present study adds to the scientific knowledge, is the visualisation of how people working in nursing homes, by drawing upon both their professional skills and their personalities, could build equal relationships and facilitate person-centredness. Except from Tellis-Nayak’s publication from 2007, there seem to be close to no literature on person-centred care that illustrate the importance of a workplace that allows the person behind the professional role to emerge, making use of both professional and personal experiences, skills and stories. Based on their and the present study’s findings, there seems to be a need for research on how to move from understanding the need of equal relationships towards how to actually acknowledge and value both persons receiving care and persons providing care as unique and capable persons.

Visualising person-centred care as something more than a technical skill or as a result of interventions, the present findings also complement models on person-centred care know-how, such as the one developed by The University of Gothenburg Centre for Person-centred Care (GPCC) (Ekman et al., 2011). The GPCC model for person-centred care (Ekman et al., 2011) provides an important framework for how to work in a person-centred way, and for evaluating the effects of person-centred care on different groups of people. What the present study adds is an understanding of the existential meanings of being person-centred, and of how being person-centred means a movement towards achieving health through occupation. Supported by McCormack and McCance’s (2010) theoretical framework that suggests that each person has the right to be respected, understood and able to execute self-determination in their everyday lives (McCormack & McCance, 2010), the present interpretations contribute with empirical support for developing a care approach that involves both doing things for another person, and being with them to share things and grow together to become co-dependent in a shared space and time.

5.1 | Strengths and limitations

Using narrated experiences of life world phenomena as a vehicle to open up for hermeneutic interpretation means that interpretation is contextual; in relation to the text in which it is interpreted, to the pre-understanding of the interpreters, and in relation to the content, structure and composition of the narratives when transformed into text. Thus, whilst other interpretations may be possible, we suggest that the interpretations made are reasonable considering the empirical narratives, theoretical lens, methodological process and authors’ preunderstandings. The study is limited to the narratives of the participants emerging out of their particular life worlds and contexts, and are thus not generalisable in a traditional statistical sense of the word. At a theoretical and interpretative level, the study findings may be transferable to contexts and participants beyond this study, for instance through reflection on doing and being within the organisation, but this is not for us to judge. Rather, the transferability of the findings will ultimately be decided by whether others will draw upon this work in forthcoming research, education and/or for practice development purposes. To attain rigour, we also addressed trustworthiness in relation to credibility and dependability (Lincoln & Guba, 1985). Credibility in terms of interviewing people working in a nursing home that had participated in a study to implement person-centred care, which meant that they had lived experiences that were consistent with the aim of the study. Dependability in terms of conducting the interviews, transcriptions and analysis during a defined period of time, involving the same three researchers, that is the authors of this study.

6 | CONCLUSION

With the aim to illuminate meanings of being person-centred as narrated by people working in nursing homes, the data analysis resulted in three themes denoting the importance of doing what really matters, being more of a person in one’s professional role, and striving to do and be better together. Interpreted in light of Wilcock’s framework on health through occupation, the comprehensive understanding of these meanings was that being person-centred in a nursing home context means becoming part of an upwards spiral that could promote the health of both people providing and receiving care. Complementing previous research and policy statements, this knowledge could be used to support implementation of person-centred care in nursing homes by illuminating what encourages people to do person-centred actions and be person-centred in nursing homes. For instance, the findings contribute with knowledge that could be used to facilitate progress beyond policy and practice requirements of providing person-centred care, by highlighting the importance of recognising, respecting and supporting both people in need of care and people who are supposed to work in a person-centred way. The findings could also be used as a foundation for future research on practical and existential meanings of being person-centred, to understand more about how to provide care that has both purpose and meaning for people providing and receiving care. Given the contextual aspects of what people do, with whom and why, a suggestion for future research is to explore facilitators and barriers for the integration of person-centred doing and being to facilitate the upwards spiral towards becoming more person-centred and to belong to a person-centred culture. Moreover, the findings could be used to elaborate on how to support healthcare workers in other healthcare contexts to become who they want to be and feel a sense of belonging to other people at the workplace. Relevant questions to ask are as follows: what can we do and who can we be to become and belong to a person-centred culture?
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AUTHOR CONTRIBUTIONS

QL involved in study concept and design, literature review and drafting of manuscript, acquisition and interpretation of data. MK involved in study concept and design, interpretation of data. DE involved in study concept and design, acquisition and interpretation of data. All authors were involved in manuscript preparation, and read and approved the final manuscript.

CONSENT FOR PUBLICATION

All participants gave permission to use their anonymised data for publication purposes.

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