Ageing in institutional care: Experiences of older adults living in a nursing home in the Northern Netherlands

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Thuis heb ik nog een ansichtkaart.
Waarop een kerk, een kar met paard
en slagerij J. van der Ven.
Een kroeg, een juffrouw op de fiets
Het zegt u hoogstwaarschijnlijk niets,
maar het is waar ik geboren ben.
Dit dorp, ik weet nog hoe het was,
de boerenkinderen in de klas.
Een kar die ratelt op de keien.
Het raadhuis met een pomp ervoor,
een zandweg tussen koren door.
Het vee, de boerderijen.

Fragment from ‘Het Dorp’ – Friso Wiegersma (1965)

Abstract

This thesis aims to gain insight into how everyday lives are experienced by residents of a care home in the north of the Netherlands. It explores how changes in policy on care for older adults affected these experiences, especially focusing social interactions and on their sense of home. Semi-structured interviews with 10 participants and observations were used in this thesis.

Through this research, valuable insights were gained into the experiences and feelings of older adults in a care home. The findings of this research suggest that interacting with residents with impairments is increasingly important because of policy changes. Because of declining body capital, residents with impairments can have difficulties forming bonds. Their impairments may hinder their ability to interact with other residents. Social bonds are further restricted because residents resist existing negative stereotyping of older adults by othering. They label other with negative aspects of bad health and actively use space to avoid them, in order to dissociate themselves from those negative stereotypes. Finding and maintaining social connections, especially deeper connections has become more difficult, and thus, social relationships between residents and staff and/or other friends and family has become more important for the residents' overall well-being. This implicates that nurses should provide person-centred care; especially recognizing social needs of residents. Furthermore, staff could potentially be actively involved in connecting certain residents to each other.

This research also suggests that the active placemaking of older adults within institutional care is disrupted by the policy changes. For instance, a quicker turnover of residents, and new residents with more complex health issues negatively influence their sense of home because it changes their sense of privacy and sense of control in public spaces of the care home. This suggests that institution-like features may become more prominent in Dutch nursing homes.

Keywords: ageing; older adults; institutional care; everyday life; social relationships

List of Content

List of tables and figures

1. Introduction

1.1 Background

The number of old people is growing in the Netherlands, both in absolute and in relative terms. The prognosis is that the number of people over 65 years old will increase from 3,2 million in 2016 tot 4,8 million in 2040 (Stoeldraijer et al., 2016). Along with this, the number of oldest old (80+) and frail older adults is rising. The growing population of older people in the country, paired with the fact that moving to a nursing home was much encouraged after WWII (Alders et al., 2015) causes the nursing homes occupation of the Netherlands to be one of the highest in OECD-countries today. This leads to growing concerns in society about the costs for care, as well as the quality of care and the amount of care professionals available. Delaying residential care is therefore one of the goals of current policy on care, which focuses on ageing in place; staying home as long as possible as one ages (Alders et al., 2010; Klaassens & Meijering, 2015). This is based around the idea that a familiar home and neighbourhood (Milligan, 2009) and high level of autonomy (Klaassens & Meijering, 2015) can aid older adults in their process of ageing and their accompanied needs. Next to ageing in place, the idea of voluntarism and informal care instead of state-subsidised care means that informal networks, friends, family and neighbours, as well as older adults themselves are responsible for their care, rather than the public domain. These changes led to the implementation of the Long-term Care Act of 2015, which has reformed long-term care and states that the criteria to enter institutionalized care are now stricter than they were in the past. Many residential care homes ('*verzorgingstehuizen*') are either closed or transformed into nursing homes ('*verpleeghuizen*') (Van Campen & Verbeek-Oudijk, 2017)**.** Both care and nursing home populations are ageing and have more residents with severe and complex health issues, such as cognitive issues or severe physical health issues (Van Campen & Verbeek-Oudijk, 2017).

However, people who are no longer able to live independently and who meet the criteria to be able to live in a care home, are still moving to institutional care. They are living with those who have lived there before the Long-term care act was implemented. Within nursing homes, positive social relationships (Bradshaw et al., 2012; Street et al., 2007) and feeling at home (Klaassens & Meijering, 2015) are crucial for residents' well-being. Looking at social relationships, moving to a nursing home has a significant effect on type and quality of

relationships residents are able to have (Cook et al., 2006). Declining mobility means that their world has shrunk to the scale of the nursing home and its close proximity and thus the rhythms of their everyday lives have been adapted to that the routines of the institution (Harnett, 2010). Social relationships with other residents are generally described by residents of a care home as unsatisfactory (Buckley & McCarthy, 2009; Bergland & Kirkevold, 2007). Furthermore, social relationships between residents in institutional care can be hindered by impairments, such as physical and sensory impairments (Cook et al., 2006) or cognitive impairments (Bradshaw et al., 2012; Hawkins & Domingue, 2012) of the self and others. For example, older adults may feel that their deteriorating body is a nuisance to others and may therefore withdraw from society (Antoninetti & Garett, 2012; Lager et al., 2015). This withdrawal is further strengthened by the dominant negative stereotypes of older adults in society, where they are seen as a burden and as connected to illness and physical loss. This existing form of ageism of older adults has a significant effect on their day-to-day lives (Schwanen et al., 2012; McHugh, 2003), because it changes how older adults see their ageing self. This may cause them to behave accordingly, by, for example, withdrawing from others.

Regarding feeling at home, for older adults their home is especially significant for their well-being, as their constrained mobility makes home more important in their lives (Klaassens & Meijering, 2015). It is where they spend most of their time. In institutional care, it is difficult for residents to feel 'at home', because care for older adults is predominantly aimed at safety of residents and efficiency of care (Hauge & Heggen, 2006). Therefore, institutional care settings often resemble a hospital more than a home. This is problematic, because qualities such as control, autonomy, self-organization and privacy are possibly lacking because of existing routines and structures of staff and the structures of buildings with its public and private spaces. This is reflected in the idea of nursing homes as institutions (Goffman, 1961; Townsend, 1964).

1.2 Societal relevance

In Dutch society, there is much debate and concern about the quality of care in residential care (Den Draak, 2010). Exploring how social relationships and a sense of home interrelate in the context of institutional care through a qualitative approach is important because it may yield solutions to everyday problems of older adults in institutional care. This study provides a contextualization of living in such institutions, which helps to better understand how

situations arise and possibly how problems can be solved (Harnett, 2010). Using a qualitative research methodology provides us with a more comprehensible picture of everyday experiences, which brings together policy and practice. It might discover details that are significant in the life of a resident in a nursing home, but which are overlooked by policy makers (Harnett, 2010).

1.4 Scientific relevance

This thesis makes an important contribution to the field of the relationship between space and age in three ways. First, although ageing in geography is a growing area of research, it is still a lacking area in comparison to research on race, gender and class (Tarrant, 2013; Hopkins & Pain, 2007). Second, recent research in geography on ageing tends to focus on older adults that age in place (e.g. Gardner, 2011; Lager et al., 2013). However, it is important to keep documenting the everyday life experiences of those in the changing landscapes of care (Milligan, 2009; Schwanen et al., 2012; Verbeek-Oudijk & Van Campen, 2017), especially because the expected demand for institutional care in the Netherlands increases in the future because of Dutch demographic changes (Alders & Schut, 2018). It is therefore crucial to analyse how the process of ageing arises in the context of institutional care, because of the impact is has on the quality of life of these residents. Third, this thesis aims to contribute to the body of work on geographies of generational separation (Vanderbeck, 2007; Hopkins & Pain, 2007). More research is needed on age-graded places such as a nursing home (Vanderbeck, 2007), the relationships between older adults within these places, and how ageist stereotypes are resisted (Lager et al., 2015).

1.5 Research purpose

The purpose of this thesis is twofold. First, it focuses on what can be learnt from resident's narratives in their everyday lives in a nursing home, focusing especially on social interactions. Then, it explores some of the ways in which ageism is played out within these social contacts and in the context of the nursing home, to see how older adults in institutional care experience and negotiate the ageing self and their sense of home. Overall, this thesis will explore how the recent policy changes affect these concepts. The research questions are:

How have the everyday experiences of residents of a nursing home in the Northern Netherlands changed by recent care policy?

- How are the social relationships of these residents experienced?
- How is the ageing self of these residents experienced?
- How are these concepts performed in the context of the nursing home?

Data in this study are collected using semi-structured interviews and observations in the context of a case study of a care home in the Northern Netherlands.

1.6 Thesis' structure

The thesis has been organised in the following way. First, relevant key concept and theories on experiences of ageing in nursing homes is discussed. Then, the qualitative methods interviewing and observation and case study used in this study are further explained. The fourth section presents the findings of the research, focusing on social relationships and the ageing self. The last section is the conclusion, which includes a discussion, a reflection of the study and recommendations for practice as well as for future research. The appendices include supporting documents: the consent form, the interview guide and the codebook of the research.

2. Theoretical Framework

This section provides an overview of relevant theory. First, in order to contextualize institutional care, the concepts of ageing and ageism are explored in 2.1. Then, literature on nursing homes is discussed in 2.2, looking at the Dutch context, nursing homes as institutions, a sense of home in nursing homes, social interactions and then especially at these interactions in the context of gender and during mealtimes. Last, the study explores how a sense of ageing and ageism can occur in nursing in 2.3. This section concludes with a conceptual model in 2.4, which provides an overview of the discussed themes.

2.1. Ageing

First, this section of the theoretical framework shows how age is seen and how age is understood in recent human geography research. Second, this section shows how age and experiences of age and place are interrelated. Third, it goes on to describe how ageism and existing ideas of old age are present in today's society and how they have an impact on experiences of older adults.

2.1.1 Age as a social construction

In this study, age is not seen as a chronological descriptor focusing solely on the decline of the functioning of the body, but rather ageing is understood as an embodied, emplaced and temporal process (Schwanen et al., 2012) and as a social construction (Pain et al., 2000). The meaning and process of age as well as how it is experienced is depended on historical, cultural, social and political contexts (Hopkins & Pain, 2007) and thus age is seen as relational. It is important to recognize that ageing, getting and being 'old' is experienced differently by each older person (Pain, 2000).

In this study, it is understood that biological time does have an influence on the processes of ageing, as the chance of decline and illness becomes higher with age, although they are not a given (Keating, 2008; Powell, 2006). Becoming 'old' has an influence on the life situation of an older adult, as well as their rhythms of life (Keating, 2008). And, the bodily changes of age are always situated in a certain context, in which class, gender, ethnicity but also the social, political and economic climate have influences (Cruikshank, 2009). Pain (2000: 377) argues that the "socially and economically constructed aspects of old age have most

influence on the condition of older people's lives". It is therefore difficult to place people in categories such as 'young' and 'old' purely based on their age category (Hopkins & Pain, 2007), although this happens in society regularly (Weicht, 2013).

2.1.2 Age and place

In geography, research on age focuses on how space and place influence the experiences of older people (Wiles, 2005; Pain et al., 2000). Place is not just a background of one's experiences but is part of the engagement of various factors that makes the experience. Places are complex processes in that people shape places and places shape people over time and in relation to other places (Wiles, 2005). People and place have a reciprocal relationship and influence each other, in which people also have agency to create and maintain an environment (Van Hoven & Douma, 2012; Lager et al., 2013). Place is seen as a web of processes and social interactions, the nature of place "continuously made and re-made through connectivities between performative embodied knowledges, people and objects" (Ziegler, 2012: 1297). Thus, environments have the ability to shape identities, social relations and older people's experiences of ageing (Ziegler, 2012).

An important aspect of the relationship between old age and place is that of 'time' (Schwanen et al., 2012; Lager et al., 2016). Older adults are slowing down, they have slower 'rhythms'. Daily tasks that were once considered as simple, such as getting out of a chair, take on a new meaning because of frailty (Hubbard et al., 2003). The world of older adults becomes slower and smaller. This means their rhythms are different than those of other people, which can cause older adults being out of sync in a place and can cause age segregation in that they are in different places at different times than others in that place. For example, they are out and about during the daytime, when most other people in the neighbourhood would be at work. In other words, they have different time-geographies (Lager et al., 2016). In studies on ageing in place, for example, this can cause difficulties for older adults to meet their young neighbours (Lager et al., 2013).

2.1.3. Ageism

Old age and ageing is stigmatized and subjected to negative stereotyping (=ageism) (Schwanen et al., 2012; McHugh, 2003). Ageist stereotypes continue to be reinforced in everyday practices and how people behave around older people. Older adults are often seen

as a homogenous group, ignoring certain differences between them (Weicht, 2013), such as gender, nationality, ability or income (Pain, 2000). Older adults as a group are often seen as a crisis and a burden to society, predominantly looking at the high costs for care for older adults (Cruikshank, 2009; Townsend et al., 2006). There is also the overall idea that ageing is inevitably connected to illness and physical loss, reducing older people to only their deteriorating bodies (Cruikshank, 2009; Powell, 2006; Pain et al., 2000). This diminishes older adults as dependent and unwanted and shapes how society reacts to them and how older adults see themselves.

The existing ideals for ageing in today's Western society is that of being active and participating in society (Schwanen et al., 2012; Ziegler, 2012). Old age is split up into two dimensions, one of 'good' ageing, the third age, in which one is healthy, active, happy and independent, and the 'bad' ageing, the fourth age, which is associated with decline, being dependent and poor health (McHugh, 2003; Townsend et al., 2006). The third age is seen as the 'golden years'; a period of freedom of responsibilities and self-realization (Marhánková, 2014), in which older adults are healthy and can do as they want, whereas the fourth age (the oldest old) is seen as a period of physical and cognitive decline (Zimmermann & Grebe, 2014). The notion of the third age and successful ageing is based upon our fear of 'our decline and erasure, projected outward in the form of disdain and disgust for 'old' people who do not 'measure up' and who tumble down the spiral of 'bad' old age' (McHugh, 2003: 180-181). So, in that aspect, focusing on the third age, successful and active ageing, further strengthens the believes that the fourth age is 'bad' and is ageist in itself (Schwanen et al., 2012). A fear of the fourth age comes from it being associated with the last stage in life and thus with being close to death (Gilleard & Higgs, 2011). Having the idea of a fourth age serves as a tool for people to dissociate with negative aspects of ageing (Gilleard & Higgs, 2011).

Identity in later life is generally seen through, what McHugh (2003) calls 'the mask of ageing', which is the idea that beneath the old body there is still a young identity and a youthful self. This is because people find it hard to come to terms with the idea that they are getting older, and through this idea can deny the fact that one is ageing. They are actively making sure that they are not seen 'like the others' and separate themselves from the group of older adults (Cruikshank, 2009). This works negatively on the view of the whole group of older adults, as it takes away from the opportunity to show how diverse the group is.

2.2 Nursing homes

The theoretical framework will now address literature on institutional care. First, this part of the theoretical framework will provide a background to the study by discussing the Dutch context of nursing homes. Then it discusses the sense of home in nursing homes and nursing homes as institutions. After, the importance of social connections for older adults within institutional care is discussed. Particularly looking at gender differences within these interactions and the ways in which mealtimes, one of the key focuses of the observations in this study, are important for the social interactions of residents of nursing homes.

2.2.1 Dutch context on care and nursing homes

In the Netherlands, less and less people reside in institutional care, because of the focus on ageing in place for older adults (Van Campen & Verbeek-Oudijk, 2017). Until the 1980s, the Netherlands being a welfare state, the government was responsible for care of older adults and moving to institutional care was much encouraged (Van Campen & Verbeek-Oudijk, 2017). However, this led to an untenable situation in which the nursing home population was substantial and costs for care were also high, while the group of older adults was still rising in the Netherlands. Because of this, care was extramuralized and through various services at home, older people were able to age in their own home longer (Van Campen & Verbeek-Oudijk, 2017). Ultimately leading to the reformation of care in 2015 by the Long-Term Care Act. This means that older adults have to own a certain degree of health issues in order to be able to live in institutional care, organised still by the government. Older adults with lower care needs can use various services from the municipality, while staying at home.

Only the most vulnerable group of older adults still resides in institutional care. This means that those in residential care have problems with their cognitive health (75%) and severe physical problems (80%), as well as having more than two chronical conditions (85%) (Van Campen & Verbeek-Oudijk, 2017), leading to higher care needs in institutional care. In 2015, around 117.000 older people lived in nursing homes in the Netherlands. Of the Dutch nursing home residents, about three quarters is female and most are over 80 years old (60%) (Van Campen & Verbeek-Oudijk, 2017). Generally, residents are dealing with complex health problems (dementia and/or very severe physical issues) and are considered frail (Verbeek-Oudijk & Van Campen, 2017), which aligns with the perceptions of the fourth age. Older adults in institutional care often get regular visits from family, such as children or grandchildren.

Other visits, for example from former friends, are rarer because of their own age (Van Campen & Verbeek-Oudijk, 2017). Fifteen percent of older adults in institutional care gets visits only very rarely to never. A quarter of older adults rarely to never goes outside of the home, because of their health and/or because there is nobody to take them outside (Van Campen & Verbeek, 2017). Most residents have the desire to go outside more (Den Draak, 2010).

2.2.2. Sense of home in nursing homes

Feeling at home in institutional care is important for the older adult's wellbeing (e.g. Klaassens & Meijering, 2015). Moving from the own home to a nursing home is usually seen as a big change in life, linked with many emotions, often negative ones (Van Hoof et al., 2016) and can even lead to feelings of displacement (Milligan, 2009). On the other hand, for some older adults moving to a care home could provide them with the chance to make social connections and come out of their isolation, as well as regaining a part of their independence (Bradshaw et al., 2012). The decision to move to a nursing home as well as the decision on which home to live in is generally made promptly, which makes the decision and process rushed (Milligan, 2009). This could potentially lead to an unfit decision, as the nursing home may not suit the resident or is too far away from existing social networks. As a resident, having had a say in the move and understanding the need for it makes adapting to the new living situation easier (Van Campen & Verbeek-Oudijk, 2017). Generally, after a period of time, residents adapt to the daily life of a nursing home and start to feel at home (Milligan, 2009). This may be because older adults have had an active role in placemaking, by "creating and maintaining opportunities for positive place experiences" (Van Hoven & Douma, 2012: 76). In order for an improvement of their own well-being, they have actively pursued a better sense of home over time.

It is proven to be a challenge to provide both a home-like environment for long-term residents while simultaneously providing all the care they need in a safe environment (Hauge & Heggen, 2006; Milligan, 2009; Nakrem et al., 2013; Van Hoof et al., 2016). Care homes can be too protective and resemble a hospital more than a home (Hauge & Heggen 2006). Tensions can arise between personal habits of residents and routines put in place by staff, which can feel like a restricting regime to residents (Bradshaw et al., 2012; Harnett, 2010). Order, organisations and preferences of the care homes can restrict self-organization (Milligan, 2009). This then has an effect on the sense of home of residents in that it impacts

their feelings of being in charge, having a sense of control and autonomy. It also has an effect on feelings of privacy and independence.

The idea of a sense of place influences whether someone is feeling at home through several factors, which can be summarized in three themes: psychological factors (e.g. autonomy and control), social factors (e.g. interactions and relationships with others, such as residents, staff and visitors) and the built environment (e.g. personal space and belongings) (Rijnaard et al., 2016). These factors of sense of place are also important in the context of institutional care. For example, when residents talk about their institution being home, they generally talk about their own private room, rather than the whole nursing home which includes public spaces (Nakrem et al., 2013). This could point to the fact that privacy is considered one of the key factors in feeling at home (Street et al., 2007). Being able to retreat from public and social places to a private place of your own is important (Hauge & Heggen, 2006). The ability to personalise the space further adds to being in control, and is also a way of being able to express oneself and build upon one's identity (Klaassens & Meijering, 2015; Hauge & Heggen, 2006). In bland public spaces and communal rooms, this form of self-expression is often not available, as they are felt as 'belonging to' staff (Milligan, 2009).

Another impact on the sense of home is that of the care residents receive. Here, the competence and attitudes of carers is important to feel at home (Bradshaw et al., 2012). Residents feel it is necessary that caregivers do not rush when finish a care task, and that nurses take their time to listen to them. It is crucial for carers to get to know their residents, in order to create a meaningful relationship that is both practical as well as personal (Klaassens & Meijering, 2015). Klaassens & Meijering (2015) stress the need for a more 'person-centred' way of care that focuses on individual needs and wishes in residential care. Bradshaw et al. (2012) also stress this and add that the relationship between staff and residents should be 'reciprocal' and staff should also share about their own life.

2.2.3 Nursing homes as institutions

In the 1960s, work by Goffman (1961) and Townsend (1964) have shaped how society thinks about living in institutional care. The work of Goffman (1961) explored how mental hospitals resemble total institutions, and building on this Townsend (1964) studied living in residential care as an older adult. Both have led to the need of thinking about nursing homes more as 'homes' rather than as hospitals and institutions (Hauge & Heggen, 2006), in order to improve

the quality of life for those in care. For example, providing residents in residential care with smaller residential units and/or single rooms in order to resemble a more domestic setting (Hauge & Heggen, 2006). However, despite these efforts, Johnson et al. (2010)'s revisiting study of Townsend (1964)'s work revealed that characteristics and issues of institutionalization still occur in residential care for older adults; namely routinized care, batch living and the issue of privacy and control (see also Klaassens & Meijering, 2015; Hauge & Heggen, 2006). These issues will now be discussed.

First, routinized care within nursing homes has an impact on the availability of residents to shape their lives and can be significantly restricting (Harnett, 2010; Milligan, 2009). By following a set routine prescribed by the nursing home, it is difficult for residents to influence their daily routine and to exercise self-determination (Klaassens & Meijering, 2015). Their autonomy decreases. Residents have little opportunity to make their own choices, for example about when to get out of and to bed, when to eat or when to take a shower (Klaassens & Meijern, 2015; Harnett, 2010). Even small decisions, such as picking out one's clothes can be restricted because of certain (washing) routines of staff (Harnett, 2010). Through these restricting routinisation, older adults often have difficulties with continuing routines they had before being admitted to a nursing home (Nakrem et al., 2013).

Second, in institutional care there is a form of batch living, which means that residents are treated all the same as a group and there is less attention for a person as an individual (Klaassens & Meijering, 2015). Daily activities are done as a group on a certain time-schedule, such as eating together.

Third, residents of institutional care still have "reduced opportunity to develop a private everyday lifestyle" (Hauge & Heggen, 2006: 461). Many residents' activities are done in public spaces of nursing homes, where residents feel less at home and in control. More spaces where one can withdraw are needed to improve their privacy. Even within their private spaces, control over who enters Is not always available. Nurses, for example, sometimes enter without permission (Klaassens & Meijering, 2015).

However, Klaassens & Meijering (2015) stress the fact that factors institutionalization should not be seen as something that is always bad, and that institutionalization is a fluid process, in which home-like and institution-like features are present and always changing, depending on the context.

2.2.4 Social interactions in nursing homes

Previous research has established that the well-being of older adults in residential care is connected to their social networks and the contacts they have on a regular basis (e.g. Roberts & Bowers, 2014; Bradshaw et al., 2012; Street et al., 2007). However, there is some debate on which social relationships and with whom are important for well-being of older adults in nursing homes.

First, relationships with residents as compared with other residents are discussed. A nursing home is an age-segregated place and has an influence on who residents communicate with daily, in that contact usually is limited to the select group of residents that happen to live in the home at the same time, based on circumstance (Hawkins & Domingue, 2012; Milligan, 2009; Oliver et al., 2018). Older adults in nursing homes are often described as being lonely and spending large amounts of time doing nothing (Cooney et al., 2012), only with 'pockets of social interaction' in between (Hubbard et al., 2003: 100). In order to 'thrive' in a nursing home, it is important for most residents to have social relationships with other residents (Bergland & Kirkevold, 2007). Having positive social relationships with peers in a nursing home helps residents with the adaption to living in an institutional setting and helps them feel supported in their living situation. However, in order for social relationships in residential care to be meaningful and have a positive impact on a person's well-being, they have to be intimate and supportive (Bergland & Kirkevold, 2007). This is rather problematic in the light of various studies' findings which report that most relationships are superficial and non-intimate (e.g. Buckley & McCarthy, 2009; Bergland & Kirkevold, 2007). The study by Hauge & Heggen (2006) reflects this finding, and it was suggested that there was little social interaction between residents and conversations were completely falling flat when staff members were leaving. Residents felt they had little in common and little to talk about and they find that other residents are not 'on the same level' as them (Buckley & McCarthy, 2009: 392). Bergland & Kirkevold's study (2007) states that health issues of residents, such as mobility issues, physical issues or cognitive impairments may hinder social interactions (see also Hubbard et al., 2003). Residents may feel that interaction with cognitive impaired residents may impact their own mental abilities negatively (Buckley & McCarthy, 2009; Murphy et al., 2006). Also, residents feel frustrated and less safe when living with cognitive impaired individuals, as privacy and sense of control can be negatively impacted through living with impaired individuals

(Bradshaw et al., 2012; Buckley & McCarthy, 2009). These individuals may exhibit behaviour that is deemed as abnormal, disrupting daily lives of other residents. Residents have an understanding for the situation of an individual with cognitive health problems, but are still less capable of and less wanting to form a connection with them (Hawkins & Domingue, 2012; Buckley & McCarthy, 2009).

Relationships with non-residents will now be discussed. As older adults move to long-term care homes, it is often hard for them to sustain the relationships they had with friends and family outside of the home (Buckley & McCarthy, 2009). In some cases, they are geographically segregated from those networks (Milligan, 2009). Therefore, reliance for social relationships then tends to fall on other residents and staff, even though having and sustaining relationships with family and friends is one of the most important social contacts to have for well-being (Buckley & McCarthy, 2009). Generally, residents feel like those are more like-minded and they feel more connected to them, they view social relationships that are formed inside as not the same as those formed outside. This could potentially cause isolation and loneliness of residents, which negatively impacts their well-being. Feelings of being in contact with the outside world (by digital methods, reading newspapers, using the telephone and/or watching television) help older adults to feel less lonely (Buckley & McCarthy, 2009). Note that involvement in any social activities does not necessarily improve a feeling of socially connectedness. Rather, feeling connected to like-minded residents or activities that also include those from the outside are what makes residents feel less lonely (Cooney et al., 2012).

Generally, residents within nursing homes feel more socially connected to staff members than other residents and having a good relationship with staff is connected to overall well-being in nursing homes (Buckley & McCarthy, 2009; Bergland & Kirkevold, 2007; Hauge & Heggen, 2006). Next to this, staff can also play a key part in enhancing and facilitating relationships between peers (Buckley & McCarthy, 2009; Bergland & Kirkevold, 2007; Hubbard et al., 2003), especially when they know the residents well and can therefore make good matches between residents. There are also residents who do not actively seek out social relationships, who would rather be on their own and who do not believe peer relationships would add to their ‘thriving’ in a nursing home (Bergland & Kirkevold, 2007). In general, more research is needed on how and which social bonds are created through which circumstances in institutional care (Hubbard et al., 2003).

2.2.5 Feminine places in residential care

Older men especially struggle to find and maintain social connections (Davidson et al., 2003). This may also be the case for older men in residential care in the Netherlands, as about three quarters of the population in nursing homes is female, and men in nursing homes are also on average a few years younger (Verbeek-Oudijk & Van Campen, 2017). Next to this, nursing homes are considered to be a 'feminine place' (Marhánková, 2014). This means that in public spaces, older women are more present and more active and provided activities and decorations of senior places are aimed more at older women. Regularly, older men and older women segregate themselves by going to different places together (Pain, 2000), where older men more often go to places represented as masculine, such as a pub. Older men are more hesitant to participate in activities that are organised especially for the older adult (Davidson et al., 2003). Overall, they visit less activities and stay for a shorter amount of time (Marhánková, 2015). The ageing experiences of older women and older men are therefore different from each other.

2.2.6 Mealtimes in residential care

As mealtimes in nursing homes have a function that goes beyond the intake of food and serves as a site where social connections are made, the mealtime setting in residential care will now be discussed. Eating together serves as a natural way in care homes to meet new people and sustain relationships (Reimer & Keller, 2009). They also have the function to serve as a 'compass'; a reference point for the day, to know what time it is or organize other activities around (Palacios-Ceña et al. 2013). Having a certain mealtime routine in place in institutional care settings is therefore important for people in residential care, although it is also evidence of institutionalisation of Goffman (1961).

In their exploratory study with the use of observations of mealtime interactions in a nursing home, Curle & Keller (2009) found that a great deal of interaction between residents was 'making conversation'; which was generally superficial talk about the weather, the food or what happened in the dining room. Hubbard et al. (2003) claims the same in their ethnographic observational study on social relationships in institutional care settings, where talking was found to be the most important form of interaction between residents during mealtimes, with superficial topics as well as the behaviour of other residents most discussed. Less typical was 'sharing', which was sharing both more intimate, longer conversation (e.g.

about their health or family) as well as the sharing of food or personal items (Curle & Keller, 2009). Residents also assisted others, either physical, by moving walkers out of the way or opening a package, or informational, by giving advice to others. However, behaviours deemed as inappropriate during mealtimes, such as spitting and drooling, can cause rejection from other residents and segregation of those with impairments (Palacios-Ceña et al., 2013). Especially the integration of lucid individuals and cognitively impaired individuals is difficult during mealtimes (Ragneskog et al., 2011; Reimer & Keller, 2009). Residents can get annoyed or agitated by other people's behaviours, causing tensions and arguments and ruining the overall mealtime experience.

In addition, Reimer & Keller (2009) found certain factors that had an influence on the social interactions during mealtimes, such as seating arrangements, certain roles of tablemates (e.g. supportive or dominant leaders vs spectators) and characteristics of the tablemates and similarities between those. The presence of guests (such as visiting family) and staff at the tables could either hinder or facilitate conversation. Reimer & Keller (2009) call for a mealtime setting wherein person-centred care should be priority, focusing on mutual respect, providing choice, promoting independence and facilitating social interactions.

2.3 Making sense of the ageing self within an age-graded place

This third section of the theoretical framework brings together theories discussed before to see how old age is experienced in institutional care and how ageism influences day-to-day lives in such care.

The nursing home is a place of generational segregation in that it is not a place in which older people have come together based upon choice, but rather based upon age, common need and functionality (Cook et al., 2006; Oliver at el., 2018). Nursing homes are often seen as places that physically segregate the old, frail and sick in society (Milligan, 2009; Oliver et al., 2018). Older adults are emplaced in certain environments based upon their old age identities (McHugh, 2007). It is the place where people in their fourth age, the oldest old, are living. Institutional care is set in place to contain 'the visible manifestations of ageing by society, offering a form of social control over those (older) people whose bodies are decaying' (Milligan, 2009: 117). Evidence of decline and sickness are hidden away from society in these homes. Spatially segregating those that are disabled shows how society deals with realities of

ageing (Milligan, 2009; McHugh. 2003; Mowl et al. 2000). Such places are associated with the negative characteristics of age, and older adults within these places are seen as dependent and less capable (Mowl et al., 2000).

Research has shown how older people tend to resist these existing identities of old age within these places (Pain et al., 2000), sometimes by stereotyping people in the own group (Mowl et al. 2000; Lager et al., 2015). Older people who are 'fit' for their age generally tend to dissociate themselves from being of old age; they "actively create and resist particular age identities through their use of space and place" (Hopkins & Pain, 2007: 288). For example, by avoiding certain places and physically segregating themselves from groups of other people (Pain et al., 2000). Similarly, Townsend et al. (2011) found that older people ascribed negative stereotypes of old age to others and positive values to the self. Those with severe health problems accompanied with their age were seen with pity and ones that needed to be cared for (Townsend et al., 2011). How well one's body functions, physically and cognitively, has an impact (Antoninetti & Garrett, 2012). Values that other people ascribe to a person (e.g. 'a disabled elder') can cause them to segregate themselves from those older people, and older people themselves can decide to isolate themselves based upon values they ascribe to their own ageing bodies. Feeling 'too old', in part because of ageism in society, may cause older people to withdraw from that society. For example, older adults would rather come across as independent than ask for help from their social network. In relation to this, Nakrem et al. (2013) found that certain strategies to cope with other residents in nursing homes were to withdrawal from others completely.

Moreover, especially the integration of lucid and cognitively impaired residents is troublesome. This can potentially cause impaired residents to be treated with less tolerance and disrespect and even get bullied (Ragneskog et al., 2011). In Hubbard et al.'s study (2003), residents labelled those (impaired) others 'stupid/mental' or looked at them as a form of amusement. By doing this, they created a segregation and distanced themselves from those others. "Through acts of 'labelling', residents projected a 'self' that was not 'mental' or 'stupid', and, by colonising public space, the residents strove to protect and retain this sense of 'self'" (Hubbard et al., 2003: 110). Often, residents would use physical space in a way to exclude or divide those labelled as 'stupid' from others. Impairments that had to do with the body (sensory, speech or hearing impairments) were generally treated differently than mental

impairments, as in that those with physical impairments were often included in social interactions through non-verbal behaviour. Hubbard et al. (2003) call for more research on how interactions between residents are shaped by an interplay of various social, structural and cultural factors in different contexts, and this is especially important in the context of existing ageism.

Another way older adults make sense of living in an age-graded place and their own ageing self is by social comparison (Ferring & Hoffmann, 2007). Older people base their sense of ageing upon comparisons with others (Ferring & Hoffmann, 2007; Von Faber, 2002), for example the social networks or health indicators of people they know. Older people generally compare themselves with those that are worse off, so it is selective comparison, because this makes them feel better about themselves (Von Faber, 2002). They also compare themselves to older people in their representations in the media. Older adults often re-assess and redefine their situation (Von Faber, 2002). They can then use other forms of differences amongst them to resist, identify or resist certain old age ideas connected to a certain space, whilst using that space (Pain et al., 2000). For example, in the research of Pain et al. (2000), older adults created other (negative) old age identities based on class, gender and ability to distance themselves from discourses of old age.

Also, another way to make sense of one's own ageing self is by what Zimmermann & Grebe (2014) call 'senior coolness', a concept which is connected to having a positive outlook, but goes beyond that in that it is a mental attitude about keeping one's composure, keeping oneself together and viewing life from a distance. It is having a sense of indifference towards and using humour and irony to make light of one's situation. This also happened in Hubbard et al. (2003)'s study, in which older adults used jokes and irony about ageing, death and having a 'frail body' in order to create shared meaning and put their situation in a positive light. "Their social interactions reveal the older person making sense of the presence of others, interpreting behaviours, and showing an awareness of 'self'" (Hubbard et al., 2003: 109). Older adults use this positive attitude to resist the stereotypes on old age. They distance themselves and use emotional indifference to not let their old age have an effect on them. They 'distance themselves from themselves' (Zimmermann & Grebe, 2014: 28). In this way, older people try to live a dignified live, despite issues that come with their old age.

2.4 Conceptual model

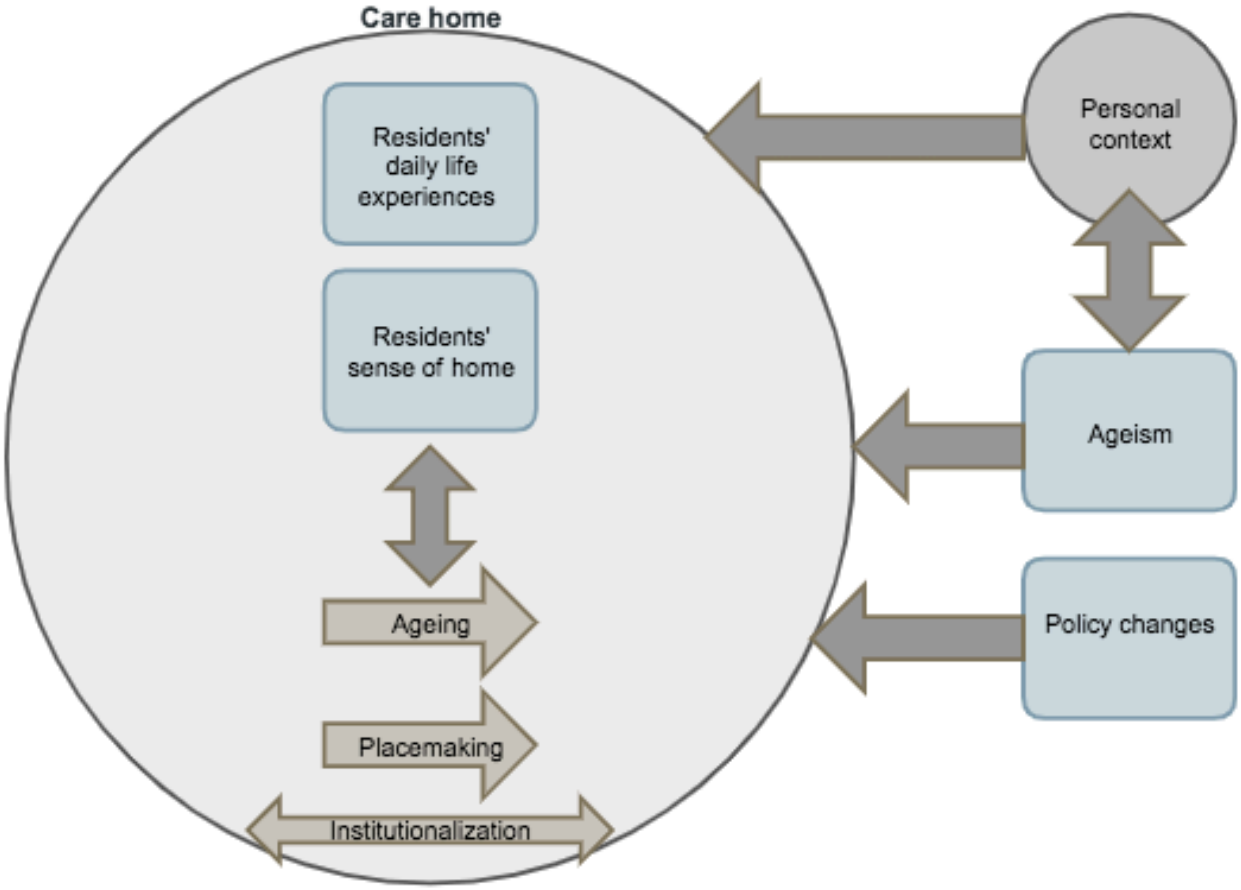

Figure 1: Conceptual model of the theoretical framework

Figure 1 illustrates an overview of the discussed themes and how they interrelate. The circle represents the context of the nursing home. Within this context, residents experience their daily lives and their sense of home. This is influenced by their ageing and their own placemaking, which are represented as arrows as time passing has an influence on them. The more time passes, the older one gets and the more placemaking one has done. At the bottom of the circle we see institutionalization. The care home is on a fluid scale of institutionalization, which is also affected by and simultaneously affecting both the ageing and placemaking processes as the daily lives and sense of home of residents.

On the right, one can see how existing ageism in society and policy plans affect all previous talked about processes. And the personal context of residents, such as for example one's age, gender and social networks, influences all processes as well.

3. Methodology

This chapter discusses the design of the study. First, qualitative methods (3.1) and especially interviews (3.2) and observations (3.3) will be discussed. Then, the location of the study (3.4) and the research participants (3.5) are introduced. In 3.6, various ethical aspects of the study are explored. Lastly, 3.7 discusses the analysis of the research.

3.1 Qualitative research

This research is based on qualitative research methods, namely in-depth semi structured interviews and participant observations. Qualitative research methods are used to get an insight into people's personal narratives and experiences, in order to find deeper explanations for people's behaviour in certain geographical, social and cultural environments (Hennink et al., 2011; Babbie, 2013). By adopting two qualitative research methods, i.e. interviewing and observing, and thus using first-person narratives as a data source, this study was able to obtain a good understanding of the daily lives and experiences of older adults living in an institutional care setting. Furthermore, adopting qualitative methods in this research allowed the researcher to explore the diversity of older people's experiences (Pain et al., 2000).

3.2 Interviews

Interviews were used because they yield rich in-depth data and provide us with an insight into the personal experiences and day-to-day-lives of the participants (Hennink et al., 2011; Dunn, 2010; Valentine, 2001). Interviewing is a good way to uncover (complex) behaviours, narratives, emotions and experiences of participants (Longhurst, 2010). It is a personalized approach, enabling clarification. Participants are empowered in this kind of qualitative research, as they get to share their ideas in their own choice of words, consequently being able to voice what they find important and what they want heard (Wakefield et al., 2007). Older people in this research were also allowed to interpret their own experiences through using interviews (Pain et al., 2000), while the most relevant topics are reflected in the key questions. When interviewing, it is important to keep listening and to return narratives back to the participant in summary form, so that the participant feels appreciated and can simultaneously confirm the findings. It is also important to establish a good relationship with the older respondent, to make them feel safe and encouraged, to leave them in a good state

at the end of the interview and to be respectful and thankful for their time (Robertson & Hale, 2011).

For the interviews, an interview guide with open-ended questions and probes was designed beforehand, see appendix 2. The semi-structured nature of the interviews provides the interview with some flexibility and room for their own narratives (Linden & Douma, 2012; Hennink et al., 2011; Dunn, 2010). Prompts were used to make sure that all relevant aspects of a key-question were discussed, as well as to ask to explain things further. The interview was structured as following; first introductory questions were asked to ease the participant into the conversation, make them feel comfortable as well as to provide relevant background information. Then, key questions were asked through different themes, each followed by a summary of the answers in that section by the interviewer. The interview is closed by offering the participant to add any other relevant information or ask any question they have. This also provides with the opportunity to zoom out and naturally finish the interview (Hennink et al., 2011).

A disadvantage of interviewing is that it is time-consuming as it is one of the slowest methods of data collection, especially when the researcher should go to the location of the respondents (Hennink et al., 2011). In the case of research on older adults, excessive story telling is generally present, with questions evoking lengthy and sometimes unrelated responses (Robertson & Hale, 2011). When that also happened a few times in this research, the interviewer let the respondent tell their story, trying not to interrupt them, in order to make them feel comfortable.

A total of 10 interviews were held and they were conducted between the 6th of May and the 17th of June, 2018. Interviews lasted between 31 and 103 minutes (average of ±65 minutes). Some interviews were kept short deliberately because of poor health and feelings of tiredness of the respondents. Interviews were audio-recorded, transcribed verbatim and put into ATLAS.ti software. Interviews were planned as soon as possible after an initial conversation, in which participants were told about the aim of the research and asked permission. Interviews took place wherever the participant preferred, to make them feel at ease and comfortable to talk. They also chose whether the interview was in Dutch or Frisian and knew the researcher already, which may further add to a sense of trust and comfort (see Butler, 2011). Most interviews (9 out of 10) took place in the resident's room, where photographs

either as decoration for their room or photographs in albums were used as probes in the interview. Some small parts of the interviews were also done while walking from/to a location in the nursing home, either before or after the interview. This would happen, for example, when the researcher met the participant elsewhere in the building and walked them to their room for the interview. Participants were interviewed as open as possible, in a form that resembles an informal conversation (Longhurst, 2010).

3.3 Observations

The interviews are complemented by participatory observations. Adding observations contributes to the research by potentially uncovering things that participants do not talk about in their interviews, either because they do not want to share certain information or because they might take certain daily things for granted. Interviews can give information that is "about what the participants say they do rather than their actual practices" (Valentine, 2001: 44). Adding observations to the research may add the perspective of these actual practices and therefore add to the data from the interviews (Hennink et al., 2011). Observations also provide contextual information to the study (Hennink et al., 2011). They work best if the researcher adopts a certain social role in the community and adapts to their practices, as not to stand out (Hennink et al., 2011). The researcher in this study already has the social role of being an employee at the case study and will therefore not identify as a researcher while observing. This is also because of the issue that doing so may influence the behaviour of the participants and therefore the study (Babbie, 2013).

Observations were performed before and after interviews, either to get a sense of the context, to provide new input for the interviews, to check results of the interviews and to supplement those outcomes. The observations were done by the researcher only and collected in a research diary. Observations were done in the months April, May and June of 2018. On-site short field notes were taken only, which were written down as formal field notes as soon as possible afterwards, either 'backstage' in a secluded office or at home. Observations included coffee time in the mornings and afternoons, lunchtime and dinnertime at the restaurant, because this provides consistency, as well as to keep the study manageable. Every setting was observed four times. Observations during mealtimes are useful as it is one of the major social events of day-to-day life for older adults, and is also one of the activities that provides them

with the opportunity to make and sustain social connections (Palacios-Ceña et al., 2013). The key-theme for the observations were the social contacts; amongst residents themselves, between residents and staff or between residents and others (e.g. visitors). Special attention was given to how residents treated other residents with impairments, because this potentially gives an insight into how the effect of policy changes in regards to more residents with complex health issues arise during social interactions.

In this research, the researcher has been a part of the case study as an employee. She has worked part-time in the nursing home for the past seven years as a part of the catering staff. She therefore helps with meals and coffee times. During some tasks, such as feeding a person, preparing a meal in front of them and bringing residents to and from the restaurant, she has had close contact with them. This is especially so during care-taking tasks, but also sometimes during other work, such as cleaning, residents would join in for a small chat. Thus, a relationship and a sense of trust between the participants of the study and the researcher was already there. This sometimes made it hard to detach from the role as employee and participate in observations as a resident only, preserving enough distance from other staff and participants (see also Harnett, 2010).

Apart from the observations, there were also reflections based upon observations the researcher made during her period of work. These were predominantly used to contextualize the findings. For example, sometimes a situation occurred which reminded the researcher of previous experiences. These observations strengthened the findings, because the researcher knew it happened many times before.

3.4 Location of the study

The study was done in a nursing home situated in a rural area in the Northern Netherlands, which was built in the 1970s. It has 94 apartments – of which 5 are intended for short-stay residents with a maximum of 12 weeks (for example for additional care during recovery from an operation) but most are for long-term residents. The home has a total of 98 residents. Of these residents, 20 are male and 78 are female. There are also four couples living together. The mean age of the residents is $\pm$85 years old, with the oldest being 100 years old and the youngest 65. Most residents need at least some physical help with their daily activities and around a third need help with getting around, for example because they are in a wheel chair.

There are some residents with beginning dementia and/or cognitive issues, such as being forgetful or having controlling issues. Residents with severe dementia are transferred to different nursing homes in the area. Residents have a single room with a small kitchen (without any cooking facilities, except for a microwave) and their own en-suite bathroom with a shower and toilet. Rooms are connected by large hallways. Every hallway has its own team of nurses, so residents are able to familiarize with the nurses taking care of them. Other staff included in the care for the residents include a team of cleaners, a team who provides food and drinks and a team who organises activities. For residents that cope with boredom, there is a special group that stays together all day, doing various activities together.

The restaurant is the largest communal room and can seat 120 people. In addition to the restaurant, there are several other smaller and larger areas for residents, such as communal living rooms for each hallway, lounges in hallways, two patios and two larger activity rooms. See photo 1 and photo 2 for a visual impression of the patio and the restaurant. Photo 3 shows the hallway right behind the main entrance, which connects to a shop, the elevators and the reception. The residency also has several small facilities, such as a hair dresser, pedicure salon, pool tables and a small groceries shop. There are also rooms for staff, such as offices, laundry rooms and a kitchen. In town, next to the nursing home building, are various other housing complexes for older adults who live independently, but who are encouraged to use the facilities of the home. There is also a closed institution for people with (severe) dementia close by. Many visitors of the care home come from these adjacent housing complexes.

The home has a certain time-structure in the sense that daily and weekly activities are set. Coffee-time, mealtimes and social activities are always on the same day and the same time. For example, in the afternoon around 1 pm dinner is served, either in the restaurant or in a resident's room with the help of a meal cart. In the evening, around 6 pm, residents either eat their 'lunch' (=sandwiches) in their own room or in the restaurant, which around 40 people do. In the morning from 9-11 am and in the afternoon from 2-5 pm residents can meet for coffee in the restaurant, in the summer this is usually held on the patio. There is also a weekly bingo, sing-a-long, physical exercising, and several other rotating activities such as crafting, puzzling, drawing or knitting. Sometimes, around twice a month, big events are held such as performances from singing choirs from around the area. People from the area and especially from the adjacent housing complexes visit these regularly. Residents can choose to go to

these activities themselves. Residents also have the ability to go to bed and to wake up at their own choice; if they are not capable of doing so themselves they can ring a nurse. The care that is provided depends on the health of a resident and what their wishes are, however, is depended on the schedule of the nurse and how many nurses are available at the time. Communication about this with nurses is as open as possible. Residents are free to move around the home as they please, and they can go out of the home whenever they want as well. They can also have visitors over whenever they want. Residents wear an alarm-bell on a necklace, for when they need assistance from nurses. The care philosophy of the home is to let the residents keep control of their lives as much as possible and provide personal care, looking at each resident as an individual with its own needs and wishes.

[Picture removed because of confidentiality, supervisor has seen it]

Photo 1: Visual impression of the nursing home, the outside patio and balconies of several apartments (photo: Dorinda van der Veen, 2018)

[Picture removed because of confidentiality, supervisor has seen it]

Photo 2: Visual impression of the nursing home, overview of the restaurant dining room, which is also the biggest communal room (photo: Dorinda van der Veen, 2018)

[Picture removed because of confidentiality, supervisor has seen it]

Photo 3: Visual impression of the hallway at the entrance, with several seating areas, a coffee-machine, a reception, elevators and a small groceries shop (photo: Dorinda van der Veen, 2018)

[Picture removed because of confidentiality, supervisor has seen it]

Photo 4: Visual impression of a hallway connecting to several rooms of the residents (photo: Dorinda van der Veen, 2018)

3.5 Research participants

Potential participants were recruited face-to-face by the researcher in her role as employee, for example after dinnertime when the respondent would be the only one left at the table. Participants were told the subject of the research, how long it would approximately take and which subjects would be discussed and were then asked if they would like to participate. It is important to note here that older adults may find it especially hard to say no to doing a research (Valentine, 2001), which may be further strengthened by the idea that the researcher is an employee. Therefore, it was important to approach the participants as comfortably as possible, and also specifically mention that they should not feel obliged to agree. Because interviews took place after the initial agreement to interviewing, participants were asked again if they would like to participate immediately prior the actual interview. Inclusion criteria for recruiting participants were: having lived in the home for longer than three years and being of relatively good (cognitive) health, in order to be able to carry on a (long) conversation and understand the whole research process, including giving consent. Nursing staff was asked permission to interview a certain respondent beforehand.

Overall, the process of finding participants, making appointments and having the interview proved to be a time-consuming process. It was difficult to get a hold of older people's time because of their health and the time schedule of the care home. During one conversation to recruit a participant, the researcher felt hesitation and stressed the fact that they should only do it if they felt truly comfortable. Then, the potential participant withdrew. Another two persons declined. On two occasions, people were accepting of doing the research, but became ill or passed away before the interview could take place. In two other cases, a date was set to have the interview, but the participants forgot the time or day and so the interview had the be rescheduled.

A total of 10 respondents were interviewed, see table 1 for further characteristics. The underrepresentation of men in the study may be a result of the existing division of older women and men in the Dutch nursing home population, where about three quarters is female (Verbeek-Oudijk & Van Campen, 2017). Another possible reason for this is that the care home's older men are less active in terms of participating at activities or being at dinnertime, as they stay in their room.

Table 1: Characteristics of the respondents

Name[a]	**Gender**	**Age-category**	**Years in c.h.**	**Lived in place of c.h.**[b]
Paul	M	80-85	10	Yes
Annie	F	70-75	3	No
Sjoukje	F	80-85	7	Yes
Henk	M	85-90	2	Yes
Pietje	F	80-85	8	Yes
Evelien	F	85-90	5	Yes
Betty	F	75-80	3	Yes
Jannie	F	75-80	4	No
Minke	F	70-75	7	Yes
Maria	F	85-90	3	No

[a] Pseudonyms are used

[b] Participant has lived in the place of the care home (=c.h.) before

3.6 Ethics

It is important to look at the ethics of a study. This part will discuss informed consent, confidentiality and anonymity and positionality issues of the research.

3.6.1 Informed consent

Doing interviews in a research study, one should always obtain informed consent (Valentine, 2001). Participants in this study signed a consent form which has written details about the research and future uses (see Appendix 1). They also voiced their permission on the recordings of the interviews, where they were told (again) that the study is anonymous, that they could quit at any time and that they could revoke answers or refuse to answer certain questions. They were also assured that their answers have no negative effect on their stay in the care home.

3.6.2 Confidentiality and anonymity

It is important to keep potential sensitive information safe and to ensure that participants will always stay anonymous (Valentine, 2001). Therefore, the location of the nursing home and identities of interviewed residents will remain anonymous in this study; only the researcher will know which information belongs to who. Certain details will be changed or omitted if it can be used to trace back to a certain person. Conclusions taken from the data will be taken with extra precaution, always looking at the broader context and the whole transcript, and at the body language before a direct quote is used to illustrate a point (Butler, 2001). Quotes are used to give participants a voice, but they will not be used to misrepresent the participants in order to support a certain finding (Butler, 2001). Participants will be referred to with a pseudonym in any written result. However, this is not sufficient to guarantee that participants are now unrecognizable. Both the researcher and the participants were aware of that during this research.

Care is taken to ensure that participants will not be harmed by the research process and the study is not exploitative. For example, participants were able to take breaks or rest at any time during the research. Rather, the research may potentially benefit participants as it may highlight a specific problem of their day-to-day lives and may yield certain solutions (Hennink et al., 2011). Another small benefit is that participants get to share their story, their views and

their experiences (Hennink et al., 2011). For example, participants in this study made comments about how nice they found it to be included in the study and to have a talkative morning or afternoon.

Data-records (transcriptions and the recordings) are deleted a year after the research. If respondents indicated that they wanted follow-ups on the research, they were given a short summary in Dutch on paper.

3.6.3 Positionality

Various positionalities of the researcher and the respondents shape research outcomes (Tarrant, 2014). On the one hand, the researcher shared her national and local identities with the participants however, on the other hand, there was a distinction between them based on age and generational differences, as well as gender in two cases. An example in which the age difference became clear was an interview in which the respondent kept calling the researcher child (for example, starting sentences with: *well, child...).* Being a young female researcher may have had an influence on the answers that the participants gave. As the researcher has worked at the study location for almost 8 years, she was an insider to the place to some extent, as she knew most of the context. Knowing the researcher beforehand prompted respondents to say for example: *'but you already know who I have most contact with',* or, when talking about somebody: *'well, you know who I mean and how he behaves...'*. However, being an insider may make it hard to detach and observe as an outsider at the same time (Valentine, 2001). Even though the researcher has her own experiences in the nursing home, she will try to listen and understand everything from the perspective of the participant (Hennink et al., 2011; Longhurst, 2010).

Also, even though the participants knew the researcher as someone who works in their nursing home and they may felt (more) comfortable with that, it may also have created the feeling that they did not want to speak negatively about the home to a 'professional', and thus there is a certain power relation between researcher and researched here (Tarrant, 2014). This may be further amplified by the educational and professional background of the researcher, who may be seen as a 'research professional' (Tarrant, 2014). There is no way to change this, but is important to keep in mind that different positionalities and different interrelations of similarities and differences between the researcher and researched have possible influence on the research outcomes (Tarrant, 2014). For example, some participants

were hesitant in interviews when it came to answers that would potentially reflect badly on the care home, saying '*oh maybe I should not say this to you'*, but the researcher then assured them that they could be honest and that the research is something separate from her work at the care home.

For the observations, it is important to understand that when research subjects know the researcher personally it could mean that there is a form of mutual influence (Palacios-Ceña et al., 2013). Especially because during this study, interaction could not be avoided. Participants started talking to the researcher as if she was working or visiting, starting to small-talk and asking her to join in for the meal or a coffee, or asking her to help with something or bring their meal. It is important to be aware of this influence, that may have resulted in altered behaviour.

3.7 Data analysis

Analysis was done based on thematic analysis as described by Kitchen & Tate (2000). First, the transcripts of the interviews were read through twice, after which coding was based upon a combination of inductive (codes arising from the data) and deductive (codes arising from the theory) thinking. An example for a deductive code in this study is that of 'feeling at home – in own room', based upon the research by Nakrem et al. (2013). An example of an inductive code is the 'turn-over of residents' code, which reflects participants talking about more residents coming and going in a shorter amount of time. A code tree was developed with the following key categories: general information, time-geographies, the ageing self, social interactions, changes in the care home, sense of home and the effects of the changes on social interactions. Then the codes and their categories were related to each other. Observations were analysed after the interviews, to see if and how they reflected the initial findings. See appendix 3 for the code book for an overview of the codes.

Even though examples from interviews in the results are translated, they are written down as close to the original verbatim transcripts as possible, including e.g. pauses (Dunn, 2010), to keep as close to the ideas and experiences of the participants as possible. This is to keep close to the emic approach of the research (Babbie, 2013).

4. Results

This chapter presents the results of the interviews and observations. It is based around four key themes that emerged from the data analysis. The chapter begins with an impression of who the respondents are and what they do in 4.1, in order to contextualize further findings. Then, 4.2 is an exploration of the nature of social contacts within the nursing home. Part 4.3 is about the ageing self and body capital in nursing homes. Last, 4.4 explores how ageism, othering and segregation occur.

4.1 An impression of the respondents

This first paragraph will provide a short overview of the respondents, in order to get to know them and to contextualize their answers.

Paul has moved to the care home ten years ago with his wife, who is now in a different nursing home because of cognitive health issues. The reason he moved to the care home was because of his wife. He now has some physical health issues of his own and uses a walker to move from place to place. He regularly has visits from his children or his former friends. He leaves the care home to visit his wife twice a week by taxi, if his health is good enough. Sometimes, he is too tired to take the journey. A few times a year, when the weather is good enough, his children take him to a pond to fish, which is one of his biggest hobbies. He also likes to listen to music and tries to read, though that is getting more difficult. He watches the news and sports on television. Paul goes to the dinnertime in the afternoon, coffee-time with his hallway and occasionally to bigger events.

Annie has moved in three years ago. She either uses a walker or her wheelchair to get around, depending on her health. She has no spouse or children, and receives visits from former friends rarely. In her spare time, she listens to classical music or church services on the radio. She also uses a laptop to email with others or to play games. She likes to watch the animals and the pond outside of her window, and when the weather is good enough and her health allows it, she takes short walks around the pond and/or care home. Annie goes to both dinnertimes and communal coffee-time. She visits other activities occasionally.

Sjoukje moved to the care home seven years ago, due to the health problems of her husband. He has passed away two years ago, and she continues to live in the same room. She has regular visits from her daughter. In the care home, she goes to as many activities as she can, therefore knowing most other residents in the care home. She also goes to the dinnertime in the restaurant in the afternoon.

Henk moved in two years ago because of his own health. He uses a walker to move around, but long walks are not an option. He tries to walk from his apartment to the street and back every other day, to keep active and healthy. He is religious and therefore watches church services on the television regularly and he also visits the church every Sunday. He goes there through using a taxi service from the church itself, where one of the church members pick up (older) people who are not able to come themselves. His main hobby is his plants, and therefore the little space outside of his apartment is filled with a lot of them. His health does not allow him to take care of them on his own, so nurses help take care of the plants while he watches. He receives visits from his children weekly, who bring him groceries. Henk goes to both dinnertimes at the restaurant, but most activities are not something he enjoys. In summer time, he likes to sit outside on the patio.

Pietje uses an electric wheelchair to get around, though she admits to something having issues controlling it. She spends mealtimes alone in her room, but goes to most other activities. She gets regular visits from family and former friends who still live in the area. She used to take a lot of trips outside of the care home, but admits that due to her health she rather stays in the home now. She likes to read and watch television. She is very talkative and most of her time is spend on talking to nurses, residents or people on the streets.

Evelien uses an electric wheelchair to get around, however, she can also walk short amounts (such as from her wheelchair to a chair in the restaurant). She used to be very active in various political boards in the area, and because she likes to continue being involved she is now in the 'resident council' of the care home, where she can voice her opinion on life in the home. She is also on the 'food board', discussing quality of food and what food to serve. She has a television, radio, tablet and laptop for entertainment. Through these digital methods, she also

keeps in touch with her family. Evelien visits the coffee-time once a week, and eats at the restaurant in the afternoon every day. She rarely goes to other activities.

Betty has both a normal wheelchair and an electric wheelchair, which she uses to go outside. She regularly visits friends and family in the village with it, and goes to various shops. She is from the area herself, and therefore knows a lot of people still. She also has family living close by. She visits the restaurant at dinner-time in the afternoon, and sometimes goes to other activities. She has close bonds with staff and nurses. In summer time, when it is good weather, she spends half of her days on the patio in the sun.

Jannie is not from the area, but moved to the care home with her husband, who was. He passed away a year after they moved, and then she moved into a new room in the home. She has regular visits from her daughters, who often eat with her at the restaurant. She spends most of her days at the special 'activity group' who stay together all day, in order to combat her boredom. Sometimes, she visits friends or family outside of the home with the use of a taxi. In her spare time, she watches television or calls people for a chat. Jannie uses a walker to get around.

Minke is one of the youngest of the care home. She moved to the care home seven years ago, because of severe health issues, and is now almost immobile. She only has limited ability to use one hand, and she can still speak softly. She is in a wheelchair, and needs help to get around. Because of her care needs, she has a lot of contact with nurses. She says she enjoys spending time with them as has a good bond with most of them. She is from the area and knows a lot of people in the care home, she also has regular visits from former friends as well as her close family. She eats at the restaurant at both times. She does not visit a lot of other activities or coffee-time. She spends her pastime watching television or by looking out of the window.

Maria has spent the last three years in the care home. She uses a wheelchair to get around. She does not get a lot of visitors, as her close family either lives too far away or they are old and not very mobile themselves. Her two children visit a few times a year, and she speaks with them on the phone a lot. Her hobbies are knitting, watching television and taking care of her

plants. She visits the restaurant for communal coffee-times sometimes, and goes to many other activities.

4.2 Social interactions

Within the topic of social interactions in the day-to-day life in the nursing home, three dimensions emerged: the time-geographies of the interactions, the nature of the interactions and the effect of gender on social relationships.

4.2.1 The time-geographies of the social interactions

Because of declining capabilities of the body, physical mobility of participants decreased. Therefore, most respondents spent a majority of their time in their own rooms and in the common rooms of the nursing home. Most respondents did not leave the home at all. In line with this, as their physical abilities declined, a big part of their time was spent on taking care of themselves:

> *(Henk) Eh.. what else do I do, oh well, I spend a lot of time on myself, first of all, and then I have already lost a lot of time [in a week]*

Majority of the residents' time was spent around the activities of the nursing home, mostly the coffee mornings and the mealtime in the afternoon. Most respondents ate their meals in the afternoon in the dining hall, about half visited the coffee mornings regularly and almost all visited weekly activities such as hallway coffee-meetings, crafting, singing or bingo. Since the weather was warm most of the time during the time of the interviews, almost all respondents talked about spending time together on the patio during the day. In the winter the patio is closed, which, according to respondents, meant that there was less social interaction between residents, however, they would meet more in hallways or at coffee-time in the restaurant. Overall, time-geographies of the respondents were largely the same, as most participants shaped their lives around the rhythms of the nursing home. They often spent their days doing the same (planned) shared activities in the same place, resembling batch living (Klaassens & Meijering, 2015). This is why residents mostly meet in communal rooms or in hallways. In these public spaces is usually where their first contact is made, as first meetings happen at random; whenever residents are placed together or happen to meet each

other. Most residents do not like to visit each other in their rooms and have no activities they do together unless these are planned by the home (see also Milligan, 2009). Social interactions were thus scheduled around the institutional routines (Harnett, 2010). The scheduling of resident's lives around the routine of the home reflects the institutionalization of nursing homes (Goffman, 1961).

4.2.2 The nature of the social interactions

In line with other studies, participants express that they find it important to be in social contact with other residents (e.g. Roberts & Bowers, 2014). However, they also explain that this contact is mostly superficial (see also Buckley & McCarthy, 2009; Bergland & Kirkevold, 2007). In neighbourhoods, informal local social contacts and a sense of familiarity with the social neighbourhood in the form of e.g. greetings on the street is important for the well-being older adults (Lager et al., 2015; Gardner, 2011). In the context of institutional care, where the home of older adults is considered age-graded and where older adults are concentrated in the same space, the same can be said. Respondents stated that they found it important to know other residents, to greet one another and to have some small-talk during meals.

However, contact does not often seem to go beyond being superficial. Participants also talked about feelings of disappointment or not feeling fulfilled after contacts with other residents. They expressed the feeling of wanting a deeper connection and less superficial contact. For example, Henk:

> *It is usually superficial, [the contact with other residents], there are hardly any deeper conversations. And that eh, see, eh, with that you could support each other and eh, yes, that is not done as often as I think it should, the people [here] sometimes need a.. eh.. a..*
> *(Researcher) A good conversation?*
> *(Henk) Yes, a good conversation! Not just that humdrum talk of eh, the weather or something*

This finding was also found in the study on older adults in residential care in the Netherlands of Van Campen & Verbeek-Oudijk, 2017) who state that this longing of intimacy could contribute to feelings of loneliness. Ageing in a nursing home means spending significant amounts of time with peer-residents. This may suggest that it is easier for older adults in

nursing homes to form social relationships with others. However, as their social network has shrunk to the nursing home, their options and choice of who to have contact with has become more limited and this makes forming relationships harder in most cases. The same happens when older adults age in place, as seen in the research of Lager et al. (2015), where having other older adults nearby in the neighbourhood did not prove to be fruitful for social capital. As living together in nursing homes is not based upon similarities in interest, but on the shared need for assistance, social relationships between residents cannot be self-evident.

On the one hand, respondents express the wish for better bonds with other residents, however, on the other hand respondents claimed they did not actively look for more than superficial contact themselves. For example, some would never and other hardly visit each other in their rooms. They said that for closer bonds and deeper conversations, they would go to (former) friends and family. The experienced disappointments of contact with other residents may make them withdraw from trying at all.

Participants also look at staff for social relationships. About half of the participants state that they found the contact they had with nurses better and more substantial than the contact with the other residents. For example, Maria says:

> *Yes.. sometimes it is [better]. There are residents you can't really talk with anymore and well the nurses have kept up with the times so that makes it easier.*

This is in line with other studies (e.g. Hauge & Heggen, 2006; Buckley & McCarthy, 2009), and shows that residents do not necessarily have to have close connections with residents to thrive (Bergland & Kirkevold, 2007). Having a good relationship with staff can just be as important for the well-being of residents.

4.2.3 Social interactions and gender

As there are fewer male residents, male respondents express that they find it harder to connect with others, as they prefer contact with other men and have '*fewer men to choose from'* (Paul). Men and women were often voluntary geographically separated, for example in communal rooms, men often seated with men and women with women and in the restaurant certain tables were thought of to be for men only: '*at coffee-time we [men] have our own*

table' (Paul). On the outside patio, observations suggested that men regularly seated themselves at the edges of the patio and were not often an active part of the conversations. Henk stated he finds it hard to connect with the women in the home and their topics of conversation, which he described as gossiping and '*typical old lady talk'* (Henk). As there are more women, and older women are generally more active in making contact (Lager et al., 2015), public spaces within the nursing home were dominated by women and can be seen as feminine places (Marhánková, 2014). Thus, gender has an influence on the experience of place in the public spaces of the nursing home.

4.3. The ageing self within the nursing home

Building upon these social relationships within the case study, this section explores how participants feel about their ageing self and how their body capital influences social interactions.

4.3.1 Residents' ageing self

Being in a concentrated space of old age, residents were more likely to be confronted with negative aspects of the ageing self, such as illness and deaths of other residents. Respondents recognized that more respondents had died in the last few months compared to a few years prior and that they saw more residents would come and go. The recent reforms in institutional care and that newcomers have more complex health issues may contribute to this.

When asked if respondents felt old, they said that their mind felt young, but they felt old when they felt their deteriorating body and when they had to come to terms with the things that they were not able to do anymore. Here, their embodied experience of old age includes loss of physical ability (Mowl et al., 2000). There are several strategies in how participants coped with their declining body capabilities. First, participants coped with their ageing self by accepting their situation and having and keeping a 'sense of coolness' about it (Zimmermann & Grebe, 2014). In some cases, this was connected to using humour play down their own situation. Second, they found replacements for what their body could not do anymore. For example, Annie, Evelien and Pietje all liked to play music and/or sing, however, their bodies made it unable to do so anymore, for example because of loss of ability to use the hands or because of fatigue. They now listened to (classical) music on the radio most of the day. Third, participants stressed the fact that they needed to keep doing things and keep

busy to pass the time. The answers they gave also showed that they took pride in being busy. For example, Betty proudly said:

> *I am a very.. they say, we called you many times, and you are never there. I am always busy, then here, then there.. I am not here [in the room]!*

She hinted at being busy throughout the interview, also saying that other residents know her as being busy all the time. This may suggest that an appearance of a busy body was seen as important, to be able to hide the declining body capital and keep close to the ideal of the active older adult. Fourth, and related to this, they tried to bring purpose into their lives by actively keeping up to date with what is happening around them, for example, Annie:

> *Of course, do I want to be up-to-date. Yes, I do keep track of it all. I don't want them to think that old fool does not know anything. No.*

Here, Annie does not only keep up to date with what is happening around her in order to keep herself busy, she also does this in order to distance herself from negative stereotypes of older adults. By keeping up-to-date she ensures that she is not seen as '*an old fool*'.
Through these strategies, we are able to see that older adults in institutional care actively negotiate their own ageing self and deteriorating bodies.

4.3.2 Body capital and social interactions

The relationship between body capital and social interactions in the nursing home became visible in two ways, i.e. by hindering social interactions and by residents withdrawing from other because of their declining body capital.

First, the idea that body capital can hinder social interactions (Antoninetti and Garett, 2012) was found. For example, respondents shared that they would sometimes avoid conversation with those with speech impairments, because they could not understand them. Another example is that, during the observations, three residents repeatedly tried to include a woman with sensory impairments (mostly trouble hearing) into their conversation, but gave up after she did not understand them a few times. Then, during the next meal, she was largely ignored by the residents, and when some tried to make conversation other residents would

say '*oh don't bother, she doesn't hear you anyway*'. Second, residents were found to be withdrawing from interactions with others because of their body capital. For example, Minke, when asked about going to the nursing home activities, describes how she does not want to join because she feels her deteriorating body and physical impairments are a hinder to others there:

> *No [I don't join] because I can't do anything. I don't feel like doing that. I have to sit like this and this, or else, because I can't hold anything on my own […] and my shaking […] het is a whole ordeal, I don't want that.*

She, and other residents, also talk about how their wheelchair takes up a lot of space and therefore, they sometimes feel like a burden to others. Thus, their dependence on others to make room for them or to help them in other ways may potentially make them withdraw from public activity in order to not come across as dependent and incapable. In this way, the existing ideals of active ageing (Schwanen et al., 2012) may hinder social relationships, even within fourth age groups in institutional care.

4.4. Effects of social interactions

This section explores in what ways residents deal with living with other residents. It first looks at how residents interact with other residents with impairments. Then it explores how othering and segregation are a result of peer-resident interactions.

4.4.1 Treatment of those with impairments

A finding of this research is that because of the recent care reforms, newcomers of the care home have more complex health issues. Evelien, about how her social relationships and her spatial behaviour have changed now she has noticed newcomers are having more cognitive issues:

> *Well eh, I don't feel like sitting in that room anymore to drink coffee... Or to sit in the hall [with others]. I don't feel like doing that anymore. I'd rather stay home then, I like reading, within my own place and [I prefer] to be on my own over being with eh, with them*

Also, residents in this study express that they 'dumbed down' and changed the conversation to be at the level of other (usually cognitive impaired) residents. So, for these respondents, these kinds of contacts may feel unsatisfactory and potentially add to feeling less connected to other residents. For example, Evelien describes how she converses with residents with an impairment:

> *You can't eh... just have a talk with everybody... You have to eh… talk on their level, what they do, and what they say…[…] that you can really notice, like ohh, something is not right here. Then I just let them talk.*

These kinds of disappointments from contacts with others eventually led some respondents of this study to retreat or intentionally keep contacts on a more superficial level (see also Lager et al., 2015). Especially when the impairments of others made them feel uncomfortable (see also Bradshaw et al., 2012). Some respondents stated they would rather spend time alone, or be in contact with other friends or family, for example through digital methods such as e-mailing, than have social contact with other residents.

Furthermore, participants describe many scenarios in which there are feelings of irritation and less tolerance of impaired individuals. More than one participant describes how one particular resident gets bullied and talked about. When Betty talks about this particular resident, she puts on a squeaky voice to impersonate her and she makes sounds which represent her heavy breathing. Minke also describes the situation with this resident:

> *When she was healthier, she was part of them. And now they count her out. And then they talk about her behind her back and I cannot deal with that kind of behaviour...*

4.4.2 Othering

A way through which participants resisted existing ideas about being of old age (and being in the fourth age) and thinking about themselves and their declining bodies, is through comparing themselves with others (Von Faber, 2002). This comparing to others ultimately led to a division between them and others based on negative factors of old age. Ageism and othering are reflected by how residents with impairments are treated. For example,

participants talk of those with cognitive health problems with pity (‘*that poor thing’* - Paul). This is an example of when other residents are seen as people that need to be taken care of. In these situations, conversations and interactions are held with a sense of compassion. The finding of Townsend et al. (2011) describes that older adults ascribe negative stereotypes of old age to others in order to positively value themselves. They see those with severe health problems as ‘other’, as people that need care. This is how participants actively separate themselves from those ‘others’, so they are not seen and/or feel like them. In this study too, respondents talk of others as *‘poor or mental’*, to potentially distance themselves from those descriptions (see also Hubbard et al., 2003). This especially happens to residents who are thought of as being ‘too far gone’, and were talked about by most residents as those that do not belong in the nursing home altogether, they say ‘*that one does not belong here’* (said by Paul and Pietje both) and refer to them as needing to go to a home for more intensive care**.** But the opposite also happens when discovering how residents deal with existing ageism. For example, Annie, refers to herself as ‘*an old fool’*, while Henk thinks younger people do not want to talk to him at church because he is ‘*that old man’*.

In addition, the difference between those in relatively good health and those who are not is also represented through different social roles (Milligan, 2009). An example in this study is that of the helping older resident. Participants describe how they adapt to living with impaired individuals by helping them when they can, and thus taking on a role of the carer. This gives them a sense of fulfilment:

> *(Paul) Well I do have a sense of fulfilment when I help [name] […] I pour his drink, because he shakes so much you know […] And I put his chair closer to the table. What I can do, I do.*

> *(Evelien) I am perfectly able to mash up the potatoes and cut the meat.. […] She is 91 years old and can’t chew everything anymore. So I will mash everything, make everything small so she can swallow it and I put some gravy on there. And then she says: oh you made [the plate] so beautiful for me again! And well, I have a feeling of fulfilment then.*

Interestingly enough, even though this is generally positive for both parties and creates a special kind of bond, this is also a way of othering. Residents create a division between those needing care and those providing care; those that still have the capability to be active and

help others, in order to manage their own ageing self. Those that need care are looked at with pity and concern and as 'victims' of old age (Townsend et al., 2006).

4.4.3 Segregation within the nursing home

Age-graded spaces in neighbourhoods offer the opportunity for older adults to come together based on a shared age-identity, such as in the case of Ziegler's (2012) and Pain et al.'s (2000) researches. However, such spaces can also actively be avoided, as seen in the study of Lager et al., (2015) and Mowl et al. (2000), because age-graded spaces can represent negative ideas about old age. Milligan (2009) describes how within institutional care, where in essence every space is age-graded, groups are formed around those who are relatively fit and those who are not. Within this case study one particular space in time is contested and avoided and here physical segregation exists. This is visible in the evening mealtime (see also Palacios-Ceña et al., 2013). Here, residents that are described by others as impaired mostly eat together and there are less older adults who are in good health than during mealtimes in the afternoon. Participants describe how they do not want to join in the evenings because of feelings of uncomfortableness. Pietje, when asked why she eats her meal alone in her room:

> *Because there are a lot of people there who can't properly eh, who are [being] dirty with their food and I cannot handle that…*

Participants describe how they do not want to join the meal in the evening because of residents drooling, messing with their food, having their fake teeth on the tables or because of unwanted behaviour such as shouting, getting angry or deciding where others should sit and why. Furthermore, during this mealtime, the presence of more nurses for every resident than during mealtime at noon also indicates these health issues. These nurses help with preparing the food or feeding residents by hand. During observations, the mealtime was regularly disturbed by other residents, for example by someone walking off angrily before everyone had finished their food (shouting '*this takes too long, some people eat so slowly!*'), or someone starting singing loudly. This then caused commotion amongst the others, who were irritated by others' behaviours and who loudly stated their (negative) opinion about this behaviour. It also caused other residents to keep quiet, eat their food and look down to avoid conversation or other interactions. This is in line with research that shows that during

mealtimes the integration of cognitively impaired and lucid individuals is especially difficult (see for example Reimer & Keller, 2009). Interactions between residents during the evening mealtime were most often 'making conversation' (Curle & Keller, 2009), where they talked about the weather or the activities of the next day. However, inappropriate behaviour would sometimes completely disrupt this talking, resulting in complete silence at the table. Staff would then try to start conversations, most often not successful. Overall, this resulted into people staying in their room to eat or people trying to seat together with residents that behaved accordingly.

In short, this section shows how older adults can actively avoid places that are associated with negative values of old age (see also Pain, 2000). Certain places are avoided because of another residents' behaviour. This reflects the difficulty of the integration of lucid and cognitively impaired individuals, which is especially complicated and visible during mealtimes (Ragneskog et al., 2011), ultimately resulting into rejection and segregation of residents.

5. Conclusion & discussion

Drawing on a qualitative study of older people in a care home in the Northern-Netherlands, this research aimed to answer the question: *How have the everyday experiences of residents of a nursing home in the Northern Netherlands changed by recent care policy?*

This thesis has explored the experiences and feelings of older adults in institutional care, especially in the context of recent policy in the Netherlands. It has found that the policy changes affect residents in three ways. First, the social relationships between residents change. Second, their sense of home can be disrupted by social disturbances resulting from policy changes.

First, attention was paid to the nature of social relationships. Here, it was shown that, just as in the context of ageing in neighbourhoods (Lager et al., 2013), a sense of familiarity with the environment and the people that live close by and having superficial and informal contacts with those adds to feelings of well-being. It also shows that relationships outside of the nursing home are more important to well-being than relationships with other residents, as those are often to be found lacking in depth. This study found that it is especially difficult to connect with residents with complex cognitive health issues because of various reasons, reflecting various other studies (e.g. Ragneskog et al., 2011). First, their declining body capital makes it difficult to communicate with others or makes them withdraw from others. Second, these residents are actively avoided by others because of they are labelled with negative characteristics of ageing. This research has shown that the integration of lucid and cognitively impaired individuals is problematic, especially during mealtimes. As research shows that more older adults with complex health issues will live in Dutch nursing homes in the future (Verbeek-Oudijk & Van Campen, 2017) it Is important to examine how the integration can be improved. A possible implication of this finding is that staff could help with integrating and forming connections between residents, for example by stimulating conversation or pairing up residents. Social connections are especially important for older adults in care, and if peer-resident connections are rarely formed or constrained by health problems, nurses should also take on the approach of person-centred care (Klaassens & Meijering, 2015), actively keeping a social relationship with residents and recognizing their social needs (Hauge & Heggen, 2006). For example, by taking time to listen to a resident's stories or problems. Special attention

should be given to older men in care, as this research indicated differences between male and female residents. Older men found it more difficult to connect with others, as there were less men overall and activities that were offered did not always reflect their interests.

Second, this study suggests that policy changes had an effect on the active placemaking of older residents (see also Van Hoven & Douma, 2012). Their strategies of placemaking and thus their agency in ageing well and making their care home a home were disturbed. This partly because of a perceived quicker process of new residents coming and residents leaving, either to go to a more specialized nursing home or by more deaths. Residents also noticed that newcomers were often dealing with complex health issues. This has a possible effect on how often social disturbances happen, which affects feelings of privacy, control and thus their sense of home. In order words, the institutional characteristics of the care home potentially increase because new residents have more complex health issues. Klaassens & Meijering (2015) call for a more nuanced approach of home and institution-like features, where they are not opposites but rather a fluid scale. In this case study, the care home added characteristics of institutions, such as less control and less privacy in public spaces and stricter routines because nurses had less time overall for care needs. Further research on how policy changes affect institutionalization of Dutch nursing homes is recommended.

This thesis aimed to contribute to cultural geographies of ageing. It has done so by adding to the understanding of old age experiences in age-graded places, namely in institutional care (Vanderbeck, 2007; McHugh, 2007). The research has shown that even within an age-graded place and amongst older people, spaces are used to navigate through spaces associated with negative stereotypes of old age in nursing homes and segregation between the fit and unfit comes about. In this case study, this happens mostly on the basis of ability of others. Some places within the care home, such as the restaurant during the evening meal, are associated with older people with declining abilities and health problems, and thus avoided by other 'healthier' residents. In this way, older people resist existing stereotypes of old age and distance themselves from them. Older people ascribe negative stereotypes of old age to other residents in order to positively value themselves (Townsend et al., 2011). The 'others' are either those that are viewed with pity and that need care, or those that are considered mental and do not belong. In this way, existing ideals of the active older adult (Schwanen et al., 2012) impact social connections between older residents, because those that are seen as inactive

are less valued, ultimately leading to them being less sought out to have contacts with. The 'others' can also be those that are deemed as ones in need of care. This can also lead to othering, as they are looked down upon with pity. However, this can also result into a positive bond as residents can be supportive and caring towards them, taking on a role as caregiver. It is recommended that further researches further research explores how and when othering of residents occurs.

Although this research is only based on a small number of respondents, it adds to a better understanding of the daily lives of nursing home residents during the changes in the landscapes of care (Milligan, 2009). Through the narratives of the respondents' experiences, this study explored how macro-environments in the Dutch context influences daily experiences of nursing homes' residents. A suggestion for future research would be to explore how existing stereotypes of ageing are reflected and empowered through policies or how existing policies are understood and used by older adults. Also, research on a larger scale could reveal insights and patterns into the differences between types of nursing homes. As well as a larger sample could explore how differences and similarities between residents occur, based on e.g. gender, ability, income, class or place of residence before admission.

For future research the perspective of older adults with cognitive health issues are significant to explore. The insights of this group of older people is underrepresented (Ragneskog et al., 2001). As this research suggest that integration between this group and other residents is often difficult and that residents with cognitive health issues are often segregated from others, it is important to understand how they experience day-to-day life in institutional care in relation to their well-being. A limitation of this study is therefore also that it is missing the perspective of those with cognitive health problems.

Overall, this study added to understandings of experience of old age in institutional care. It revealed that interactions with those with impairments is increasingly important and residents notice this in their everyday life. It is important to keep documenting the lives of those in institutional care to be able to find solutions that matter in their day-to-day lives.

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Appendix 1: Consent form (in Dutch)

Bedankt voor het meedoen aan dit onderzoek! Deze masterscriptie wordt vanuit de Faculteit Ruimtelijke Wetenschappen van de Rijksuniversiteit Groningen uitgevoerd. De begeleider van de scriptie is dr. Bettina van Hoven. Voor eventuele vragen kan er naar dorinda_vdv@hotmail.com worden gemaild.

Dit onderzoek gaat over de dagelijkse levens van bewoners van een zorginstelling in Nederland. Er zijn in dit interview geen goede of foute antwoorden mogelijk en het gaat vooral om uw persoonlijke ervaringen. Het interview neemt ongeveer 45-60 minuten in beslag. De interviews worden alleen gebruikt voor de beschreven masterscriptie en eventuele andere academische output. Alle data wordt vertrouwelijk behandeld, en elke participant die wordt geïnterviewd blijft anoniem met behulp van het gebruik van fictieve namen.

Ik, als participant, heb het recht om mijn toestemming op elk moment weer te kunnen intrekken, zonder daarvoor een reden te moeten opgeven. Ik heb verder het recht om altijd verdere vragen over het onderzoek of het interview te stellen.

- Ik stem toe met deelname aan het onderzoek.
- Ik stem toe met het opnemen van het interview.
- Ik stem doe dat geanonimiseerde voorbeelden uit het interview kunnen worden gebruikt in de verslaglegging en voor eventuele andere academische output.

Datum: ……..-……..-……

Naam participant:

Naam onderzoeker:
Dorinda van der Veen

Handtekening:

Handtekening:

Appendix 2: Interview guide

Introduction
I am conducting this research for my master at the University of Groningen. This research will be about the daily life in institutional care.

- This interview will take around an hour and will be in the language of your choice
- Anonymity (identities are non-traceable, names will be changed)
- Consent form
- Consent for recording (explain why, and that it will be deleted after a year)
- Explain that the participant can ask for breaks and quit at any time
- Explain that participants can revoke answers they have given at any time
- Any questions before we start?

Questions

Introducing questions / background information
Could you tell something about yourself?

Ask for participant's age, what place they're originally from, any children, what profession they had, religion, things they liked doing, have they travelled a lot, did they have a lot of contact with people in their environment before, certain milestones in life.

Core questions
1. Background
1.1 What was the reason for coming to the nursing home originally?

(How long have you lived in the nursing home, what image did you have of institutional care, did you come with their partner, how was the medical condition then)

1.2 Can you describe to me what the living situation was like in the first years?

(How did it feel to have to move to a nursing home, how did it feel in the first period, how did you adapt to living here, what did the whole building look like, what was the atmosphere, what facilities did you use, any special arrangements, how much help from nurses did you have?)

2. Situation now
2.1 How have you felt living in the nursing home in the last few months?

(How satisfied are you living here, how much help from nurses, current medical condition, do you feel at home & why & where (room vs whole building), what are positive/negative things about living here, can you share some good experiences here in the home)

2.2 What factors, in your experience, are important to live as good as life as possible in the nursing home?

(Do you feel old, when do you feel old, when does your age hinder what you want to do, do you feel old in comparison to others, what is being old to you, do you feel older living here)

2.3 Can you describe what you do in a typical week?

(Where do you eat and why, how many activities do you go to, do you leave the nursing home and to do what, what are typically good & bad days, how much contact with/visits outside family/friends, how much contact with nurses, how do you keep in contact with the outside world)

What are your favourite places in the home and why?

2.4 Can you tell something about the social contact with other residents?

(When & where do you have these contacts? What do you typically do with other residents? What do you typically talk about? How do you feel when you spend time with other older adults living here? How would you describe the relationship with other residents? In what situations do you feel positive about your contact with other older adults? In what situations do you feel less positive? What are factors that make it hard (& easier) to come in contact with other residents?

Do you feel connected to other residents? Do you feel similar to other residents? Do you feel part of a group? What is the influence of others on your wellbeing?

Do you compare yourself to others? Do you help others in giving others assistance and in what ways?)

2.5 Are there moments when you feel disturbance caused by the behaviour or problems of the other residents?

(When, in what ways, how often, where, what do you do when this happens, how does it make you feel when this happens)

3. Changes from then till now

3.1 How do you feel living in the nursing home has changed from when you first arrived here till now?

(Building, activities, staff, residents, general atmosphere, health, time spent with help from nurses, sense of home)

3.2 How much do you feel has your social life changed from then till now?

(Could you describe the relationships/friendships you have made over the years with other residents, could you describe the relationships with outside friends/family, nurses, who do you have most contact with during a week)

3.3 Can you share about what happens when new residents move in?

(Do you try to get in contact with them, how do you compare yourselves with them, do you feel similar to them and/or how do you cope with feeling different than them, how do you deal with new residents who are different from you in terms of mental disabilities or physical disabilities and in what ways do you try to help these residents?)

Closing questions

Is there something you would like to add to the interview?

Are there any questions about this interview or the research?

Thanks for participating.

Appendix 3: Code book

Main codes	Sub-codes	Semi-codes
General Information		
Age		
Place of birth		
Place of living before admission c.h.		
Health problems		
Marital status		
Children	Grandchildren	
Hobbies	-Hobbies from before -Hobbies now	
Personal – other		
Time-geographies		
Daily activities		
Activities alone	Care for self	
Activities communal	-Mealtimes -Coffee times -Other activities	
Activities outside of c.h.	-Transport	-Self -Taxi -Picked up by others
The ageing self		
Declining body capital	-Decline of health -Small world	-Unable to do something because of decline -Activities take more time
Strategies	-Finding a replacement for what they are unable to do -Finding other hobbies - Accepting situation - 'Keeping cool'	
Effects of ageism	-No longer feeling like doing something because of age	
Social interactions		
Places of SI	-Mealtimes -Activities -Room peer-residents -Other places c.h.	

	-Outside of c.h.	
SI peer-residents	-Positive -Negative	-Gender
SI nurses	-Positive -Negative	-Close bonds
SI others from outside of c.h.	-Family -Friends	-Important for well-being
Nature of SI	-Superficial -Close bonds -Digital methods as replacement	-Disappointment -Not looking for more -Important for well-being
Sense of home		
Feeling at home	-In room -In c.h. - Positive feelings - Negative feelings	 -Restaurant -Hallways -Other communal areas - Decoration of room - Knowing people - Missing old home
Changes in care home		
Turnover of residents	-More deaths -More people leaving to other nursing homes because of health	
Change in nurses	-Nurses seem busier -More nurses during mealtimes	
New residents – health	-Physical health -Cognitive health	- Negative - Negative - No big change
Change – negative	-Atmosphere worse -More disruptions	

Social effects of changes		
Treatment of those with impairments	- Positive - Negative	-Understanding -Adjusting - Helping - Annoyance - Avoiding - Less interactions - Less substantial interactions
Othering	- Comparing by ascribing negative qualities of age to others -Social roles	- Laughing at display of cognitive health issues - Negative labelling - Labelling others with pity - Helping others positive Helping others negative
Segregation	-Avoidance of spaces -Forming of groups	- Because cognitive health others -Because physical health others - Communal areas - Mealtime evening -Staying in room - Based on health - Based on gender