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**Being perceived as a “visitor” in the nursing staff’s working arena – the involvement of relatives in daily caring activities in nursing homes in an urban community in Sweden**

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## **AUTHOR CONTRIBUTION**

J. Holmgren was involved in the study design, data collection and analysis, and manuscript preparation. A. Emami was involved in the study design, critical revision of the manuscript and linguistic revision. L. E. Eriksson was involved in the study design, critical revision of the manuscript and linguistic revision. H. Eriksson was involved in the study design, data analysis and critical revision of the manuscript.

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# **Being perceived as a “visitor” in the nursing staff’s working arena – the involvement of relatives in daily caring activities in nursing homes in an urban community in Sweden**

## **ABSTRACT**

**BACKGROUND:** It is both complex and difficult for relatives when a loved one moves into a nursing home and many relatives are not prepared for the realities these new situations entail. Little attention has been paid to scrutinising the involvement of relatives in patient care, particularly in relation to the structures and routines of nursing homes or to the staff’s reasoning concerning their involvement. **AIM:** To describe, from a gender perspective, how nursing staff’s routines and reasoning act to condition the involvement of relatives in nursing homes. **METHODS:** Focused ethnographic fieldwork was conducted in a medium sized urban community in central Sweden in three different nursing homes. Ethical approval was granted by the Ethical Review Board (No 2010/658-31/5). **RESULTS:** The nursing staff assign a certain code of conduct to all relatives they perceived as “visitors” in their working arena. This code of conduct was related to the routines and subcultures existing among the nursing staff and stemmed from a division of labour; the underlying concept of “visitor” predetermined the potential for relatives’ involvement. This involvement is explicitly related to the general gendered characteristics that exist in the nursing staff’s perception of the relatives. **DISCUSSION:** The study’s limitations are primarily concerned with shortcomings associated with a research presence during the fieldwork. The discussion focuses on the dimensions of power structures observed in the nursing home routines and the staff’s reasoning based on their gendered assumptions. We argue that it is important to develop mechanisms that provide opportunities for nursing staff in elderly care to reflect on these structures without downplaying the excellent care they provide. We stress the importance of

further exploring these issues concerning relatives and their involvement in nursing homes in order to facilitate the transition from informal caregiver to “visitor”.

**Keywords:** nursing home staff, relatives, involvement, ethnography and gender perspective

## **INTRODUCTION**

Many relatives continue to take part in the care of their relatives after they have been moved to special housing (1-4). This caring responsibility is most often passed to female family members, including wives, daughters and daughters-in-law (5), a common practice in an already intra-gendered caring arena in which women provide care for both other women and men (6). Given the gendered positions of men and women in society in general, institutions and practices are almost always connected to various power structures and gender concepts (7). It is therefore important to investigate how these influences are reflected in nursing homes and how they condition the gender-specific involvement of relatives. Previous research on the relationships and interactions between relatives and nursing staff in special housing has focused on communication, role transition, attitudes and interventions designed to improve the cooperation between staff and relatives, often including both relatives and nursing staff in these studies (8-12). This study was focused on the perspective of the nursing staff, as they usually have both the mandate and authority to plan and execute daily caring activities in nursing homes (13).

According to Nolan and Dellasega (14) and Utley-Smith et al. (3), interacting with relatives is often one of the most difficult, complex and demanding tasks for nursing staff. Wilson (15) argues that although nursing staff recognise that family members represent a helpful resource, they tend to prefer completing their tasks without their help in order to assure that the nursing home's routines are strictly followed. Furthermore, the extra time required to involve relatives may come at the expense of providing the best possible care for the residents (16). Scarce resources, high staff turnover and poor support from the nursing home management are other possible factors deterring the nursing staff from engaging family members (10, 17). Abrahamson

(18) also emphasises that these factors can lead to burnout and stress among the nursing staff, which may negatively impact their relationships with relatives.

Nursing staff has also reported that some relatives have distorted expectations of the care the nursing home should provide and these expectations often conflict with those of the nursing staff. These relatives may be described as demanding, difficult and challenging (19, 20) and relatives are often perceived as selfish if they fail to realise that the home's finite resources must be allocated fairly among several residents and relatives (3). Kellett (21) found that the nursing staff tended to believe that good relationships with family members are characterised by the readiness of relatives to rely on the staff's professional skills and to relinquish the responsibility of care (cf. 22). Furthermore, the relatives are expected to value the staff's caring efforts (6) and follow the nursing home's chain of communication when seeking information or communicating with staff (3). The accepted rules and customs in these social arenas are usually influenced by the staff's normative beliefs about how to interpret a family member's behaviour (6) Although extensive, this previous research has paid little attention to exploring, from a gender perspective, how the routines and reasoning of nursing staff condition relatives' involvement in daily caring activities.

West and Zimmerman's (23) gender display perspective emphasises that gender is connected to the division of labour, which comprises the resources, structures and processes vital for the creation and maintenance of gender differences. In this study, rather than viewing routines and reasoning as separate components, the gender display perspective asserts that they are inextricably linked to the ways in which we "do gender" when defining social positions. The division of labour in a nursing home is central to this gendering process, as it defines the social



positions and roles available to the relatives. Thus, the gender display perspective implies that doing gender is a process in which differences are created, while concurrently recognising that these differences are subject to change. The underlying notion in the gender display perspective is that gender is created and expressed through dichotomies such as man - women and heterosexual - homosexual, as well as more subtle dichotomies including formal - informal, working - visiting, and normal - abnormal (24). West and Zimmerman argued that positions of power are distributed within these dichotomies; because the two parts are not equal, a central mechanism is created that reproduces and (re)affirms social positions in a gendered society (23).

The gender perspective is highly relevant when examining the involvement of family members in institutions such as nursing homes. Intra-gendered structures also tend to emerge within nursing homes, as the majority of both the nursing staff and the relatives involved in care are female, and nursing home institutions could be described as feminine encoded arenas (25). Studies using a gender perspective often, but not always, focus on power structures (26) and how gender is created between men and women, as well as within these groups (27-29). In this study, the gender perspective forms the basis for examining how the routines and reasoning of the nursing staff act to condition the involvement of relatives in daily caring activities in nursing homes in an urban community in Sweden.

## **METHODS**

### **Setting and participants**

Participants were recruited from a medium sized community in central Sweden. Of the five nursing homes in this community, three consented to participate in the study following an

information session. These nursing homes admitted elderly people with major care needs, such as disabilities and/or problems concerning nutrition, hygiene and dressing, and offered their residents full-time supervision. Importantly, the nursing homes did not admit persons suffering from dementia. The three nursing homes were also similarly structured; three story buildings in which each floor had a kitchen, twelve resident apartments equipped with security alarms, staff offices, and public areas decorated with old furniture in order to make the institution more home-like. The television and radio were often on in the living rooms. In all nursing homes, the kitchens were considered to be the "heart of activity"; the place where nursing staff and residents could meet, eat and talk. In the kitchen the staff prepared the food, washed the dishes, distributed the medicines and planned the day. The residents spoke very sparingly with one another, a phenomenon the nursing staff attempted to overcome by encouraging conversation. Each day, the residents were offered group social activities, such as dining, musical entertainment and excursions in the surroundings.

The participants in this study were permanently employed nursing staff from the three nursing homes. A total of 42 staff members received verbal and written information about the study and all but one gave their informed consent to participate. Among the 41 informants, there were 38 women and 3 men, ranging in age from 23 to 64 years old. The specific job titles of the informants included 6 registered nurses, 22 enrolled nurses, 8 nursing assistants, 3 heads of units and 2 administrative staff (both with nursing backgrounds). The informants had been employed in 50 to 100% positions in nursing homes from three to seventeen years.

## **Data collection**

Data was collected over a four-month period from the three nursing homes through focused ethnographic fieldwork, an ethnographic approach previously used in nursing research (30-33). The method consists of participant observations, formal and informal interviews, and the gathering of documents. Focused ethnography was chosen for this study as the research questions concerned a distinct problem within a specific context among a group of people (34).

The first author (JH) collected data from the three nursing home over numerous observation sessions while the nursing staff performed everyday work: 14 sessions (87 hours) in the first home, 9 sessions (47 hours) in the second, and 7 sessions (46 hours) in the third, for a total of 30 observation sessions and 180 hours. The observations were conducted through a gender perspective in order to capture how the staff unconsciously did gender, particularly with regards to their perceptions of and reactions to the ways in which relatives involved themselves in caring activities. Although the purpose of the ethnographic field work was not to study the relatives' and/or residents' perspective, it was natural to come across them because of their presence in the nursing homes. The residents were asked to give their consent if they accepted that the data were collected in their homes in observing the nursing staff while they cared for them in their apartments. The relatives received written information which was posted in existing information points in the nursing homes to inform that a research study took place in the public areas. No relatives questioned the study or the first author's presence in the nursing homes. The observations were documented on site and recorded into a word-processing program as field notes, including descriptions of places, activities, events and relationships, as well as reflective memos. The memos were then used to identify additional areas that required further examination.

In connection with the observation sessions, 19 informal interviews were conducted with the nursing staff wherever an interesting situation arose, including in the common kitchen, hallway, coffee room or the residents' apartments. These informal interviews provided instantaneous insight into the nursing staff's reasoning during various situations and a better understanding of their conduct. The interviews, which lasted on average 10 minutes, took place during or in connection with various events and were initiated by either JH or the nursing staff. In addition, five formal interviews were conducted with the three directors and two nurses, lasting an average of 35 minutes. The formal interviews were structured according to a predetermined interview guide and provided an opportunity to focus on issues that had emerged during the observations. The informants were asked questions such as: What happens when relatives criticise the nursing care? To what degree do you feel that the relatives are responsible for the residents' quality of life? All interviews were tape-recorded and transcribed verbatim. Finally, as part of the ethnographic method, data was also gathered by reviewing documents, such as the nursing homes' introductory brochures targeted to residents and their relatives.

### **Data analysis**

The data were analysed using thematic content analysis in four steps, as described by Baxter (35) and in relation to the theoretical frame of gender display perspective (23). Step 1 - The interview transcripts, field notes and introductory brochures were read through in order to get an overall impression of the data. Simultaneously, the recorded interviews were listened through in order to acquire the most comprehensive impression of the data possible. Step 2 - The data were read through more carefully and condensed meaning units were assigned. The analysis was carried out based on a gender perspective in order to understand how the nursing staff's routines and reasoning conditioned the relatives' involvement in daily caring activities in nursing homes. Step

3 - The meaning units were further condensed into codes, maintaining the original character of the meaning units. Step 4 - Abstraction was completed through the interpretation of the coded data using a theoretical gender framework, based on the general themes that were developed. In those cases in which JH found that one code could be related to several themes, the last author made a co-author check in order to facilitate the clustering of the codes into the most relevant themes. For more detailed information on this process, please see Table 1.

Insertion point Table 1

### **Ethical considerations**

The study was granted approval by the Regional Ethical Review Board (No 2010/658-31/5) and the relevant ethical guidelines were followed (36). Although the focus of this study was to observe the nursing staff's conduct, the residents unavoidably became a part of the observation; therefore, informed consent was collected from the residents as well as the participating nursing staff. If a resident did not consent to participate, the first author respected their wishes and avoided observing the nursing staff in the resident's apartment or the public areas where they were present. All participants were guaranteed confidentiality and the right to withdraw at any time without any restriction. The people that visited the nursing homes such as relatives, craftsmen, dentists, physiotherapists, occupational therapists etc. were informed through newsletters at the homes' billboards, that there was an on-going research study in the public areas.

### **RESULTS**

The analysis of the data collected in this study resulted in the development of three themes illuminating how the nursing staff's routines and reasoning effectively conditioned the involvement of the relatives. These themes are: 1) a division into formal or informal caregivers -

contributing rather than competing; 2) status of relatives in the nursing staff's working arena - code of conduct for "visitors"; and 3) spectrum of characteristics connected to relatives' involvement. In general, the degree and type of involvement of the relatives in the nursing homes seemed to be conditioned by a gender display of the dichotomous divisions of formal - informal, worker - visitor, and normal - abnormal.

### **Division into formal or informal caregivers – contributing rather than competing**

Although the nursing staff agreed that relatives should take part in daily caring activities, they also believed that certain areas of decision making fell strictly under their jurisdiction and in such cases their authority should not be shared with relatives. The nursing staff explained their reasoning for the division of staff and relatives into formal and informal caregivers, respectively, with reference to the multidimensional nature of their work. One enrolled nurse described the basis for this division in a formal interview in the following way:

It is hard, I do not actually think that relatives should be allowed to decide what concerns [the residents]... my God, they can be involved in what the residents should wear or what they should eat for dinner ... but somehow the relatives forget that we are experts in caring and they are not. But then again, they think that they know their mom or dad for whom we are caring and I can understand that. But that was when they were healthy, not now...

As seen in the quotation above, the use of word "expert" and the importance of "now versus then" shed light on the significance of the relative - nursing staff divide. The self-labelling of the nursing staff as experts predetermined the position of the relatives as informal caregivers, a narrow and restrictive role. During the fieldwork observations, the staff demonstrated this type

of role distinction through both verbal and non-verbal communication with the relatives. For example, it was commonly observed that the staff marked their territorial authority by making the relatives wait in public areas while they performed their daily care activities in the residents' apartments.

Although the nursing staff acknowledged during informal interviews that the relatives had a great deal of experience in caring for their family members, they saw this experience as confined to a certain time period. In this respect, the caring skills of relatives were considered somewhat out-dated or inappropriate, thereby strengthening the nursing staff's perception of relatives as informal and non-expert caregivers in the nursing homes. During the fieldwork observations, particularly during the informal interviews and coffee breaks, the majority of the nursing staff stressed the importance of setting boundaries, emphasising the inability of relatives to care for a resident as they had before. This line of reasoning formed the basis for the division of labour between the nursing staff and the relatives in the nursing home culture.

Occasionally, uncertainty was observed in the relationship between relatives and staff when relatives challenged this division of labour; such challenges required attention and correction by the staff. The staff frequently discussed this type of situation during the interviews; for example, one member of the nursing staff described the situation in a formal interview in the following way:

There could be incontinence problems, and then of course the relatives think a lot about the incontinence materials their mom or dad should have. Their view is not linked to any professional approach, they just follow their emotions that this is the way it should be. This may be an example of what is our responsibility as professionals and what the relatives

should not make decisions about ... this is just an example. Because, sometimes we find ourselves in these kinds of situations and then we have to point them out...

Despite the staff's reasoning with regards to identifying themselves as caring experts within their working arena, they tended to maintain an approving and inclusive approach to the relatives' involvement. This was observed during their interaction with the relatives while they discussed the relatives' concerns about certain caring practices or medical matters.

The division of labour was outlined in the introductory brochures, making it clear for relatives how they could be contribute as informal caregivers. Nonetheless, this division in itself seemed to create a manoeuvring space in which certain roles or types of involvement were negotiable, based on the principle of contribution without competition.

### **Status of relatives in the nursing staff's working arena - code of conduct for "visitors"**

During both formal and informal interviews, many of the nursing staff labelled relatives who entered their working arena as "visitors". In fact, the distinction between "workers" and "visitors" was crucial to the nursing staff and was compounded by the concept of pay; the nursing staff represented professional caregivers who received pay for their efforts, whereas the visiting relatives cared for their family members in their spare time. This distinction limited the possibilities for the relatives' involvement, which was only permitted if they followed a pre-set code of conduct in the nursing homes. An enrolled nurse displayed this attitude during a formal interview after a busy morning on the floor:

They [relatives] are not supposed to work extra here [at the nursing home]. We actually get paid to work here, so I usually check with them several times whether or not they really



want [to care] and can cope. As I said before, we get paid so we can do this, we've got to. You [the relative] can take it easy, have a cup of coffee and rest a bit.

Although being labelled "visitor" released relatives from the obligation of attending or participating in the caring duties, it authorised the staff restrict the activities in which the relatives were permitted to be involved. For instance, providing intimate hygiene care to the residents was exclusively allocated to the staff and relatives were prohibited from taking part in such care activities. The public - private dichotomy was frequently discussed among the nursing staff while they determined which activities or behaviours were appropriate in public and private settings. During a lunch break observation, some nursing assistants agreed that relatives should be excluded from intimate caring activities due to the discomfort experienced by both the staff and the residents when intimate care was performed in presence of the relatives. In contrast, some nursing assistants argued that the relatives themselves should be free to determine their own level of involvement based on their relationship with the resident.

Occasionally, nursing staff struggled with adult children, particularly sons, wanting to care for their parents' intimate hygiene. A nurse expressed her concerns in a formal interview in the staff's lunchroom:

...changing diapers or washing their mother or father in the genital area, may not be so... I do not know if you should call it unethical, but for me it is a bit strange. If I should start washing my mom... It belongs to the nursing staff [that kind of caring tasks]. But you may have different opinions about this. I mean, many relatives accompany the residents to the doctor and the dentist and want to know what is happening and we are pleased for that. It is this issue of hygiene that makes you think a bit...

The field observations revealed yet another dimension of the staff's perception of the public - private division, which impacted the corresponding code of conduct; for example, the activities considered "public" were almost exclusively considered to be the relatives' domain.

Accompanying patients to appointments, outdoor activities, and socializing were perceived as examples of being a good relative and the staff obviously approved of the relatives who accompanied residents to the doctor, hairdresser or podiatrist.

The restrictions and code of conduct expected of the "visitor" were not actually fixed or static but rather flexible and dynamic in relation to other intersectional positions, such as man - woman and child - parent. The concepts of women and caring were so intertwined that exceptions were sometimes made in the division of labour; for instance, it was occasionally observed that some female visitors in the nursing homes could carry out intimate care for family members. During an informal interview, several members of the nursing staff discussed a daughter-in-law who accompanied her mother-in-law to the toilet during her visits in the nursing home. Although this activity was accepted, the staff deemed it wise to exclude the resident's son from such caring activities.

### **Spectrum of characteristics connected to relatives' involvement**

The nursing staff viewed the relatives as an important resource for both the residents and themselves. This view was also communicated in the introductory brochures and in the core value statement in the nursing homes. Although the staff strongly emphasised that they knew the relatives well and strived to maintain good relations with them, they were frequently observed to judge the relatives, stereotyping them based on their ethnic origin, family relations, conduct, and

social status. Indeed, such topics frequently arose during the chatting and reporting among nursing staff.

In general, the relatives were described in both formal and informal interviews by the nursing staff as nice and friendly, with various positive characteristics. Some relatives, however, were considered to be 'difficult' to connect with and/or understand; such relatives were categorised according to gendered characteristics. This phenomenon is illustrated below in the excerpt from an informal interview in which a nursing assistant expressed her opinion about an adult son who had always lived with his mother:

He is a bit special and different. He is not strange to us nursing staff ... but he and his mother have a special relationship. I do not really think there is something strange, but it is just that he is little... you know, I think there is something wrong with him ... they do not have a normal and healthy mother and son relationship, he is very concerned about her ... he has lived with his mother his whole life and is really bound to her.

This type of judgement, in which the relative does not fulfil the requirements of a "normal" relative, demonstrates how the reasoning among nursing staff can actively place relatives in specific social positions. The classification of relatives is not only connected to gender characteristics but also affects their social privileges as "visitors". As observed primarily in informal chats, concepts such as "strange" and "odd" were used to label relatives who seemed to challenge the routines in the nursing homes. In this case, the polarization was related to a hierarchical frame. Furthermore, visitor privileges were distributed according to this norm. As exemplified in the quotation above, the son's relationship with his mother seemed to challenge both the routines and the dominant reasoning in the nursing homes.

The spectrum of characteristics attributed to the relatives was further complicated as some of the nursing staff reported that contact with the relatives was often the most challenging task in their work. Perhaps the most demanding relatives were those described by the majority of the staff as norm breakers, in relation to the we - them dichotomy. An enrolled nurse informally stated during an afternoon break:

...if you come here, you also have to learn how to speak the language [Swedish]... No, but I think that they [immigrants] have to adjust. Her relatives think that we should learn how to speak her [the resident's] language so we will understand her.

As shown above, intertwined in the gender characteristics was also a demarcation line exaggerating the we - them divide. The relatives' involvement was discussed in relation to these intersecting structures of ethnicity on the floors and aroused various feelings among some nursing staff. It was visible that the labelling of relatives as "good" or "odd" resulted in an unequal distribution of privileges by the staff. In contrast to the explicit core value statement that stressed the equal treatment of all relatives, "good" relatives were given more freedoms and choices than the "odd" relatives. For example, the requests made by relatives from ethnic minorities were more frequently ignored or neglected than those from the dominant population. Accordingly, the we - them divide was found to be greatest between the staff and the more demanding relatives, creating a better "manoeuvring space" for the good relatives and solidifying the nursing staff's collective professional identity.

## **DISCUSSION**

The particular paradigm and specific method used in a study entails certain benefits and limitations. In qualitative and theory driven studies there is a risk of bias in the interview questions, data analysis, and interpretations, due to the inherent nature of intersubjectivity (37). Qualitative approaches are impacted by the researcher's pre-understanding and theoretical perspective, resulting in the generation of a more contextual result rather than a universal one. In addition, the convenience sampling utilised in this study decreased the transferability of the informants and enhanced the contextuality of the results (34). An inductive approach was used, as our intention was to capture the informants' implicit gender perspective through observing their routines and interviewing staff members regarding their perceptions of relatives' involvement in caring activities. Thus, the nursing staff was not explicitly asked about their perceptions of gender in the interview questions. Moreover, we have chosen to merely focus on nursing staff's reasoning and perception of the relatives' participation in caregiving rather than an all-inclusive focus on the multipopulated nursing home culture. This is a common approach in ethnographic studies (cf. 34, 38, 39). Retrospectively, that can be considered as a limitation of this study. Including the observation of the relatives and/ or the residents in the analysis of the data could have enabled studying the interaction between nursing staff, relatives and residents in the nursing homes which would have made the results more comprehensive and it would have enabled to grasp the gender relations in a broader and more dynamic perspective. We come to recognize that the voice of relatives and the residents are as important for achieving a diverse understanding of nursing home practices from different gendered perspectives. Therefore, we suggest that the results in this study warrant further gender related research studies for exploring all various dimension of care giving in the nursing home.

In accordance with the guidelines from the literature, the data collection and analysis methods used in this study have been clearly described, including an analysis matrix, in order to facilitate a transparent review of the rigor and trustworthiness of our study protocol and data analysis (40). The analysis has been further verified by including representative quotes extracted from the material that substantiate the trustworthiness of the results. In order to minimise the risk of misinterpretation and bias, all authors were involved in planning the research process and the data analysis and the research team examined each author's analysis to ensure the credibility. The time frame for the data collection was another limitation identified after the completion of the study. The richness of the data would have been enhanced had the time spent in the nursing homes been spread over more days during different times of day (34).

The overall pattern that emerged from this ethnographic study based on the field observations of the nursing staff's routines and reasoning suggest that the relatives' involvement is restricted by the nursing staff's perception of them as "visitors" in their working arena. This finding is in line with previous research stressing that although relatives wish to be involved in institutional based care (1-4), they must accept a minor role due to the nursing staff's perception of them as informal caregivers (41, 42). In this study, three main themes evolved that encompass the circumstances underlying this limited involvement of relatives. Firstly, the division of labour based on formal and informal caregiving (23) represents an important demarcation line clarifying the appropriate types and level of involvement for the relatives. According to Chappell (43), such a structure of complementary care constitutes a common organizing principle in caregiving institutions. Previous research also suggests that the idea of complementary care implies that the welfare state and informal caregivers provide different kinds of care-specific services (5), a perception reflected in the nursing staff's reasoning and routines within the culture of the nursing

homes. This division of labour created a distinct manoeuvring space for relatives based on the principle of contribution without competition, though this manoeuvring space must be limited in order for the nursing staff themselves to be perceived as “professionals” (44). This also agrees with Bauer (13), who indicated nursing staff traditionally takes ownership of the nursing home arena and in doing so expects the relatives to take subordinate roles.

Secondly, upon entering the nursing home a relative effectively enters the nursing staff’s working arena and was therefore perceived as a “visitor”. The concept of pay for caring services was related to this principle and corresponds to previous findings that relatives are not always seen as legitimate carers and their expertise related to their unpaid caring responsibilities is not always trusted by staff (10). Furthermore, the division of public and private spheres led to questions concerning intimacy and relatives’ involvement; in general, the nursing staff strongly believed that the most intimate and private caring spheres were the least acceptable areas for the involvement of relatives. Nay (45) points out that an involved relative can be perceived as pushy, strange and demanding by the nursing staff and that the liberties and responsibilities they take on are sometimes considered too large in relation to what is deemed “normal”. In a former study, nursing staff preferred that relatives did not provide too much hands-on care, as this infringed on the staff’s total caring responsibility for the residents (46). Previous research has also shown that concepts like professionalism, expertise and formal education act to strengthen the nursing staff’s position as formal caregivers and legitimise the limitation of relatives’ involvement (44).

Lastly, various gendered characteristics, including dichotomies such as we – them, were important principles that conditioned the relatives’ involvement and were related to a hierarchical frame, providing markers for how privileges were distributed among the relatives (cc. 47). It has previously been stressed that nursing staff may find it time-consuming,

complicated and difficult to deal with family members, particularly those families seen as “demanding” (3). In this study, the staff occasionally experienced such families as annoying and believed this conflict hinged on their unrealistic views of the residents’ care needs and what is possible within the nursing home’s routines.

In summary, this study contributes to the picture of intertwined and complex power relations between the nursing staff and the relatives in the nursing home culture. Relatives’ involvement was described from a gender display perspective and was inevitably linked to the nursing staff’s routines and reasoning (23). Although we touch upon gender characteristics in relation to ethnic minorities, we acknowledge that relatives’ involvement also needs to be considered more exclusively as a cultural issue since traditions, religiosity and values are aspects that probably drive motives and desires for involvement, as well among nursing staff as the relatives. The results of this study are in line with previous research suggesting that relatives sometimes feel marginalised by the nursing staff, who traditionally perceives the nursing home arena as their professional territory (45). This study’s specific contribution is the demonstration that being perceived as a “visitor” in the nursing staff’s working arena predetermines both the level and type of involvement of the relatives. The findings in this study also show that subtle dichotomies, like formal- informal caregiver, working – visiting are important in reproducing and (re)affirming social positions within the nursing home culture. It also demonstrates how these dichotomies relate to gender characteristics and a dividing of we and them. Understanding female practises, like nursing homes from a gender display perspective makes it possible to discuss and elaborate on different power structures without limiting or simplifying the forces that are in circulation to only one overall polarized idea about men and women. Making these subtle dichotomies visible and show how they contribute to uphold the division of labour and a gender order in nursing environments is an important feminist and nursing practice.



## **CONCLUSION**

Being perceived as a “visitor” in the nursing staff’s working arena entailed the expectation of a specific code of conduct related to routines and reasoning that exists within the nursing staff culture; this code stemmed from a division of labour. In addition, the underlying connotations of “visitor” predetermined the possible involvement of the relatives. The acceptable type and level of involvement was explicitly related to the general gendered characteristics that exist in the nursing staff’s reasoning about the relatives.

We suggest that the dimensions of powers structures inherent in nursing homes routines and the staff’s reasoning based on gendered assumptions must be acknowledged. An education program has been planned for the nursing staff in order to disseminate the knowledge gained from this study, aiming to increase gender awareness and sensitivity concerning the role that gender perspective plays in decision making and planning regarding relatives’ involvement in the care of residents in nursing homes.

## REFERENCES

1. Naleppa MJ. Families and the Institutionalized Elderly: -- A Review. *Journal of Gerontological Social Work*. 1997;27(1):87 - 111.
2. Port CL, Gruber-Baldini AL, Burton L, Baumgarten M, Hebel JR, Zimmerman SI, et al. Resident contact with family and friends following nursing home admission. *The Gerontologist*. 2001;41(5):589-96.
3. Utley-Smith Q, Colón-Emeric CS, Lekan-Rutledge D, Ammarell N, Bailey D, Corazzini K, et al. Staff perceptions of staff-family interactions in nursing homes. *Journal of Aging Studies*. 2009;23(3):168-77.
4. Bowers BJ. Family perceptions of care in a nursing home. *The Gerontologist*. 1988;28(3):361.
5. Jegermalm M, Jeppsson Grassman E. Patterns of Informal Help and Caregiving in Sweden: A Thirteen-Year Perspective. *Social Policy & Administration*. 2009;43(7):681-701.
6. Kemp CL, Ball MM, Perkins MM, Hollingsworth C, Lepore MJ. "I Get Along With Most of Them": Direct Care Workers' Relationships With Residents' Families in Assisted Living. *The Gerontologist*. 2009;49(2):224-35.
7. Connell R. *Maskuliniteter*. [Masculinities] 2. uppl Göteborg: Daidalos. 2008.
8. Hertzberg A, Ekman S-L. 'We, not them and us?' Views on the relationships and interactions between staff and relatives of older people permanently living in nursing homes. *Journal of advanced nursing*. 2000;31(3):614-22.
9. Davies S, Nolan M. Making it better': Self-perceived roles of family caregivers of older people living in care homes: A qualitative study. *International Journal of Nursing Studies*. 2006;43(3):281-91.
10. Ryan AA, Scullion HF. Family and staff perceptions of the role of families in nursing homes. *Journal of advanced nursing*. 2000;32(3):626-34.
11. Austin W, Goble E, Strang V, Mitchell A, Thompson E, Lantz H, et al. Supporting Relationships Between Family and Staff in Continuing Care Settings. *Journal of Family Nursing*. 2009;15(3):360-83.
12. Majerovitz SD, Mollott RJ, Rudder C. We're on the Same Side: Improving Communication Between Nursing Home and Family. *Health Communication*. 2009;24(1):12-20.
13. Bauer M. Collaboration and control: nurses' constructions of the role of family in nursing home care. *Journal of Advanced Nursing*. 2006;54(1):45-52.
14. Nolan M, Dellasega C. 'It's not the same as him being at home': creating caring partnerships following nursing home placement. *Journal of Clinical Nursing*. 1999;8(6):723-30.
15. Wilson CB, Davies S, Nolan M. Developing personal relationships in care homes: realising the contributions of staff, residents and family members. *Ageing and society*. 2009;29(07):1041-63.
16. Pillemer K, Suito JJ, Henderson, Charles R., Meador R, Schultz L, Robison J, et al. A Cooperative Communication Intervention for Nursing Home Staff and Family Members of Residents. *The Gerontologist*. 2003;43(suppl 2):96-106.
17. Gladstone J, Wexler E. The development of relationships between families and staff in long-term care facilities: Nurses' perspectives. *Canadian Journal on Aging/La Revue canadienne du vieillissement*. 2002;21(02):217-28.

18. Abrahamson K, Sutor JJ, Pillemer K. Conflict between nursing home staff and residents' families. Does it increase burnout? *Journal of Aging and Health*. 2009;21(6):895-912.
19. Shield R. Wary partners: Family-staff relationships in nursing homes. In *Gray Areas: Ethnographic encounters with Nursing Home Culture*. (Stafford P ed.), 2003. NM: Sar Press, Santa Fe, 203-33 p.
20. Haesler E, Bauer M, Nay R. Staff-family relationships in the care of older people: a report on a systematic review. *Research in Nursing & Health*. 2007;30(4):385-98.
21. Kellett U. Bound within the limits: facing constraints to family caring in nursing homes. *International Journal of Nursing Practice*. 2000;6(6):317-23.
22. Söderström I-M, Benzein E, Saveman B-I. Nurses' experiences of interactions with family members in intensive care units. *Scandinavian Journal of Caring Sciences*. 2003;17(2):185-92.
23. West C, Zimmerman DH. Doing gender. *Gender & society*. 1987;1(2):125.
24. Hirdman Y. *Genus: om det stabila föränderliga former*. [Gender: about the changing forms in the stability order] 2001 Liber, Malmö.
25. Jervis LL. Working in and around the 'chain of command': power relations among nursing staff in an urban nursing home. *Nursing Inquiry*. 2002;9(1):12-23.
26. Ås B. *Kvinner i alle land...: håndbok i frigjøring*. [Women around the countries... a handbook of emancipation]. 1981 Aschehoug, Oslo.
27. Forssen A, Carlstedt G. Work, health and ill health. New research makes women's experiences visible. *Scandinavian Journal of Primary Health Care*. 2001;19(3):154-7.
28. Connell R. Glass Ceilings or Gendered Institutions? Mapping the Gender Regimes of Public Sector Worksites. *Public Administration Review*. 2006;66(6):837-49.
29. Öhman A. *Genusperspektiv på vårdvetenskap*. [Gender perspective on caring sciences]. 2009, Högskoleverket, Huskvarna.
30. Leininger MM. *Qualitative research methods in nursing*. 1985 Fla.: Grune & Stratton, Orlando.
31. Brink PJ. Traditional birth attendants among the Annang of Nigeria : Current practices and proposed programs. *Social Science & Medicine*. 1982;16(21):1883-92.
32. Lipson JG, Omidian PA. Afghan Refugee Issues in the U.S. Social Environment. *Western Journal of Nursing Research*. 1997;19(1):110-26.
33. Kauffman KS. Center as Haven: Findings Of an Urban Ethnography. *Nursing Research*. 1995;44(4):231-6.
34. Roper JM, Shapira J. *Ethnography in nursing research*. 2000, Calif.: Sage Pub Thousand Oaks.
35. Baxter LA. *Content analysis. Studying interpersonal interaction*. 1991, The Guilford Press, New York, 239-54.
36. Declaration of Helsinki. [Internet]. 2008, <http://www.wma.net/en/30publications/10policies/b3/index.html>.
37. Patton MQ. *Qualitative Research and Evaluation Methods*: Sage Publications, Inc; 2002.
38. Söderbäck M, Christensson K. Care of hospitalized children in Mosambique: nurses' beliefs and practice regarding family involvement. *Journal of Child Health Care*. 2007;11(1):53-69.
39. Salzmänn-Eriksson M, Lützén K, Ivarsson A-B, Eriksson H. Achieving Equilibrium within a Culture of Stability – Cultural Knowing in Nursing Care on Psychiatric Intensive Care Units. *Issues in Mental Health Nursing*. 2011;32(4):255-65.
40. Sandelowski M, Barroso J. Reading qualitative studies. *International Journal of Qualitative Methods*. 2008;1(1):74-108.

41. Nolan M, Grant G, Keady J. *Understanding family care: a multidimensional model of caring and coping*. 1996, Open University Press, Buckingham.
42. Sandberg J. *Placing a spouse in a care home for older people:(Re)-Constructing Roles and Relationships*. [PhD]. 2001, Department of Neuroscience and Locomotion, Division of Geriatrics, Faculty of Health Sciences, Linköping University, Linköping.
43. Chappell N, Blandford A. Informal and formal care: exploring the complementarity. *Ageing and society*. 1991;11(3):299-317.
44. Lill L. *Äldreomsorg: om makt, genus, klass och känslor i ett yrke*. [Elderly care: about power, class and emotions in a profession]. 2010, Liber, Malmö.
45. Nay R. Relatives' Experiences of Nursing Home Life: Characterised by Tension. *Australasian Journal on Ageing*. 1997;16(1):24-9.
46. Hertzberg A, Ekman S-L, Axelsson K. Staff activities and behaviour are the source of many feelings: relatives' interactions and relationships with staff in nursing homes. *Journal of Clinical Nursing*. 2001;10(3):380-8.
47. Westin L, Öhrn I, Danielson E. Visiting a nursing home: Relatives' experiences of encounters with nurses. *Nursing Inquiry*. 2009;16(4):318-25.

**Table 1.** Example of the analytical process from meaning units to theme.

Meaning unit	Condensed meaning unit	Code	Theme
We are experts in caring and they are not. But then, they think that they know their mom or dad that we care for and I can understand that. But that was when they were healthy, not now...	The staff are formal caregivers and the relatives are informal caregivers	Formal and informal caregiving	Division of formal and informal caregiving – a matter of contributing without competing
Relatives can cheer up the elderlies' everyday life through socializing because we have to focus on the daily caring activities and we do not have the same time as relatives	Relatives contribute with a social dimension that the staff say they do not have time to engage in	Relatives can help with the informal caregiving	