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RESEARCH ARTICLE

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Older adults' reasons for applying to a nursing home – a document analysis

Lisa Spang[a], Kajsa Lidström-Holmqvist[b], Marie Holmefur[a] and Cecilia Pettersson[c]

[a]School of Health Sciences, Örebro University, Örebro, Sweden; [b]Faculty of Medicine and Health, University Health Care Research Center, Örebro University, Örebro, Sweden; [c]Department of Nursing and Integrated Health Science, Faculty of Health Science, Kristianstad University, Kristianstad, Sweden

ABSTRACT

Background: Ageing in place is the social norm in Sweden, yet older adults apply for a nursing home on a daily basis which suggests that ageing in place needs further study as it is not suitable for everyone. Aim: to study descriptions of older adults' reasons for applying to a nursing home in documents of granted nursing home decisions.

Materials and methods: One hundred and sixty decisions were analyzed through document analysis with a deductive content analysis using the Canadian Model of Occupational Performance-Engagement (CMOP-E) as a framework.

Results: Reasons for applying were represented in the three factors of the CMOP-E. In personal factors, reason for applying was e.g. connected to severe anxiety. In environmental factors, family culture had an influence in the application. In occupational factors, the ability to perform self-care and mobility greatly affected decisions to apply to nursing homes.

Conclusion: Descriptions of the older adults' activities in daily life were limited. If OTs were further involved in nursing home applications, adults ageing in place could be better supported and a move to a nursing home may be prevented. Significance: this study contributes to the understanding of why older adults chose to apply to a nursing home.

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Ageing in place; Canadian Model of Occupational Performance-Engagement; qualitative analysis

Introduction

The increasing ageing population makes the discussion of where older adults with somatic diseases (without a dementia diagnosis) should live and receive care constantly relevant [1]. An international societal norm for older adults is to age in their homes (to age in place), with support from family or/and society [2]. Ageing in place has been defined as remaining in one's home and community with some level of independence and social support rather than in a nursing home [3]. Yet, the knowledge of older adults' experiences of ageing in place, especially in those who wish to move to a nursing home, is limited. Despite this gap of knowledge within this group, ageing in place has been described as desired by older adults [4]. However, research has also shown that this desire decreases with older age [5]. With age, the human body suffers biological losses [6] that affect both occupational performance and the kind of activities in which people choose to participate [7]. For older adults with somatic diseases, loss of occupational performance is one reason for wishing to move to a nursing home rather than ageing in place [8,9].

To move in older age has been described as demanding and could be initiated due to many reasons [10]. Especially for nursing home applicants, a move can be triggered by hospitalization, declining health, or a decreased level of independence [9,11]. However, to take the step towards a nursing home application can be a long and arduous process, where the older adult often depends on a relative or healthcare professional to initiate and fulfil an application [12,13].

Different countries have different regulations and organization of elderly care making the context important to consider when studying older adults who want to move to nursing home instead of ageing

CONTACT Lisa Spang lisa.spang@oru.se School of Health Sciences, Örebro University, Fakultetsgatan 1, SE-701 82 Örebro, Sweden
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in place. In Sweden, where this study was performed, ageing in place is supported by the municipal health- and social care system. Support in daily life is provided through subsidized social services such as home-based care carried out by assistant nurses, food service and the Personal Emergency Response System (PERS alarm) [14]. In addition, support can be provided by healthcare professionals such as occupational therapists (OTs) or through home health care provided by nurses [15]. OTs enable the older adults to live as independently as possible through housing adaptations [16], and by providing interventions to sustain or improve occupational performance and/or to compensate for disabilities [17]. As a consequence of the support provided to age in place, beds in nursing homes for older adults with somatic diseases are limited as older adults are expected to continue to age in place [18].

The desire to move in older age has been studied from various perspectives [4,10]. To move to a nursing home has previously been studied in interview studies with a limited number of participants [9,11] and there is a need for studies including larges samples. Granted nursing home decisions include a bigger sample of life stories and can thus further contribute to the knowledge base on reasons for why older adults move to nursing homes. Moreover, to our knowledge, theoretical occupational therapy perspectives are rarely used when analyzing older adult applying of nursing home care and can add new perspectives to the knowledge base. The Canadian Model of Occupational Performance and Engagement (CMOP-E) (19,p.22–27) can be utilized as a theoretical framework, as the model has an unique focus on engagement, meaning to attend or engage in activities without being involved in the actual performance or doing of an activity, and its importance in daily life. Previous research has shown that engagement is central to older adults, and they value the possibility to stay engaged even though health declines and they experience a loss of energy [9,11]. In, addition, CMOP-E is based on the dynamic interaction between the factors of person, environment and occupation, which together constitute the foundation for occupational performance and engagement. The model CMOP-E also allows for an analysis that differentiates the factors included to evaluate where imbalances in occupational performance may occur [19]. In this study, 'imbalance' is defined as negative experiences of ageing in place that affect the desire to apply for a nursing home. To study these negative experiences through the lens of occupational justice, which is defined as having the right to engage in occupations, could identify barriers to engagement in daily activities that may affect older adults negatively (19,p.211–213). Understanding these barriers could contribute to knowledge on how today's society live up to the demands of occupational justice in the older population. Additionally, connecting barriers in daily life to occupational justice could be beneficial for clinical occupational therapists to not only focus on obstacles in daily life at the individual level but to practice identifying occupational injustice at the societal level.

In conclusion, studying granted nursing home decisions from an occupational therapy theory perspective such as CMOP-E could add new perspectives to the understanding of which parts of life that need to be better supported while ageing in place. The aim of this study was to study descriptions of older adults' reasons for applying to a nursing home in documents of granted nursing home decisions using CMOP-E as analysis framework. The study's research questions were: How are personal factors described in the decisions? How are the environmental factors described in the decisions? How are occupational factors described in the decisions?

Materials and methods

Granted nursing home decisions were analyzed by means of document analysis according to Bowen [20].

Study design

Document analysis is a qualitative systematic procedure (20) that starts with an evaluation of whether the content of the documents is comprehensive or selective, balanced or unbalanced. This evaluation aims to determine whether the document holds enough information to answer the research questions. According to Bowen [20], the documents' content is then further analyzed and synthesized in categories using content analysis. Since Bowen does not supply a specific content analysis, a deductive manifest content analysis according to Elo & Kyngäs [21] was used in this study to synthesize and categorize data in the documents based on the three research questions at issue based on the factors of CMOP-E

Data collection

In Sweden, a nursing home application can either be granted or denied by a social welfare officer. Social welfare officers are trained social workers who follow the Social Service Act [14], which guides them in evaluating older adults' life situations and need for

care when applying for a nursing home. As all included applications in this document analysis were granted, thus they will henceforth be referred to as 'decisions'. Inclusion criteria for this study were: a decision for older adults with somatic diseases and needs, but without dementia diagnoses. Somatic needs were defined as having impaired health, impaired body function or multiple diseases related to old age.

The decisions were structured in accordance with the guidelines of the Swedish National Board of Health and Welfare, using the headings of the International Classification of Functioning, Disability and Health's (ICF) [22] domains; health condition, body functions and structures, activities, participation, personal factors, and environmental factors. The content of the decisions was based on records from the municipality (notes from meetings with social welfare officers over the years, assessments from OTs when available and home healthcare nurses, communication with the nursing home applicant or their relatives, etc.).

The decisions were collected in 2021/2022 and were granted in the years 2019–2020. To estimate the number of decisions needed, Braun and Clarke's suggestion for a larger document analysis were applied, meaning that 400 documents were collected [23]. A social welfare officer working in a medium-sized municipality in Sweden was instructed to collect 200 decisions for each year using a stratified sample (randomly select decisions from each month). All decisions were de-identified by the social welfare officer before sending them to the research team.

Data selection

All 400 decisions were scanned and numbered. Information was collected on gender, age, living arrangements, where the applicants were staying when they applied and who initiated the application. They were read carefully to evaluate the content and estimate their information power [20,24]. Information power was estimated, and 400 decisions were judged to be too extensive for a qualitative analysis. Information power was judged to be reached with 80 decisions from each year (80 decisions was comparable to 20 transcribed interviews). It was noted that the Covid-19 pandemic began to influence the lives and decisions of older adults in spring 2020, and even though the study was not about the effects of the pandemic, we wanted to see if it had an influence on applying for a nursing home. Therefore the data was divided into two domains, one for the pre-pandemic period (January–April 2019) and one for during the pandemic (May–December 2020). Consequently, all calendar months were represented in the analysis but spread over two years. A total of 160 decisions were selected, comprising 761 pages of text. For further description of the 160 decisions, see Table 1.

Analyses

The document analysis began by evaluating whether the content of the decisions were comprehensive (contained sufficient information) or selective (contained insufficient information) in order to answer the research questions [20]. The evaluation was conducted by the first author (A1). Questions asked during this evaluation were 'Are there information under all headings of the decision?', 'Did the text give a sense of the person and his/her life story?' and 'Are the person's needs well described?' The decisions were also judged by A1 and A4 to be balanced (well-written information under each heading) or unbalanced (missing headings or very brief or thin descriptions) by carefully reading and summarizing each decision's content. The majority were comprehensive and balanced; four were selective, and another four were unbalanced. Each decision gave a picture of the applicant's life and described several domains of daily life, as well as how the needs of daily life could no longer be met within the current housing arrangement.

Table 1. Further description of the 160 decisions.

	2019[a] ($n=80$)	2020[b] ($n=80$)
Age, years		
Mean (SD)	84.7 (10.1)	85 (7,3)
Median (min-max)	86 (47-99)	86 (66-101)
	N (%)	N (%)
Gender		
Female	43 (53.7)	54 (67.5)
Male	37 (46.2)	26 (32.5)
Living arrangement		
Living together with someone	21 (26.2)	16 (20.0)
Living alone	59 (73.7)	64 (80.0)
Residence		
Apartment	41 (51.2)	52 (65.0)
House	10 (12.5)	12 (15.0)
Townhouse	10 (12.5)	3 (3.7)
Sheltered housing	19 (23.7)	13 (16.2)
Place during application		
Hospital	2 (2.5)	10 (12.5)
Short-term care facility	45 (56.5)	38 (47.5)
Ordinary housing	30 (37.5)	32 (40.0)
Nursing home	3 (3.7)	0 (0.0)
Who initiated the application		
The older adult	45 (56.5)	45 (56.5)
Relatives	26 (32.5)	29 (36.8)
Healthcare professionals	6 (7.5)	6 (7.5)
Head of department at nursing home	3 (3.7)	0 (0.0)

[a]2019 contained decisions from month January to April.
[b]2020 contained decisions from month May to December.

The next part of the document analysis was to analyze the content of the decisions using qualitative content analysis. The steps of deductive content analysis by Elo & Kyngäs were applied [21]. The first step of the analysis was to create or identify a structured matrix. A literature review was performed to find a suitable matrix linking ICF to factors in COPM-E, as the decisions was structured using ICF. No suitable matrix was identified, but one paper [25] could be used as inspiration for the development of a matrix. A1 used Stamm et al. [25] together with theoretical literature [19,26] to create the first draft of the matrix. In the theoretical literature, Townsend and Polatajko (19,p.33–36) argue that ICF's personal factors (a person's life story and lifestyle) align with CMOP-E's person variable. However, in the decisions ICF's personal factors included descriptions of individual interests and leisure activities. Therefore, personal factors were analyzed to be more about occupation than and were placed under CMOP-E's occupation in the created matrix. All authors discussed the matrix, and after minor text adjustments a final version was established (Table 2). After this first step in the analysis process, a deductive and manifest content analysis was performed using the remaining steps by Elo & Kyngäs [21]: (2) data gathering by content, (3) grouping and (4) categorisation.

Step 2

Data gathering by content was performed by all authors (all female OTs experienced in qualitative analysis). Each author gathered information from the decisions under the headings in the matrix. For example, the applicants' abilities to perform activities were gathered under the heading 'Activities and Participation', such as used a walker, needed support with personal hygiene and clothes, etc. Data gathering was conducted using triangulation for the first 80 decisions, with the authors first undertaking the gathering separately and then together in joint discussions and comparisons of descriptions. A2, A3 and A4 analyzed and gathered data for 20 decisions each (10 in each year), whereas A1 analyzed all 80 (40 in each year, including the ones analyzed by A2–A4). During this time, it became obvious that the decisions provided descriptions from different perspectives – from the applicants themselves, from relatives and from healthcare professionals. However, through joint discussions, it was agreed that even if other people affected the decision to apply for a nursing home, it was interpreted to be a reason to apply, e.g. due to an assertive relative or based on recommendations from healthcare professionals. The remaining 80 decisions were analyzed by A1.

Step 3. Grouping

A1 produced an initial grouping, where data were clustered into subgroups to answer the research questions posed. For example, for the question of how environmental factors were described in the decisions, the collected data were sorted into subgroups within the environment, such as social, cultural, physical, and institutional.

Step 4. Categorisation

The grouping was abstracted to preliminary subcategories under each research question. The *preliminary subcategorisation* and results were then validated by A4, who compared the results with the data gathering and grouping from all 160 documents. The final categories are presented in the results section.

Table 2. Matrix linking the major variables of CMOP-E and domains in ICF.

Major variables in CMOP-E	Definitions of the major variables in CMOP-E	Domains in ICF
Person		
Cognitive functions	Cognition, mind, and intellect	Health condition/Body functions and structures
Physical functions	Action and performance based on motor and sensory characteristics	
Affective functions	To feel or experience e.g. sense of security or autonomy	
Spirituality	A pervasive vitality and sense of meaning, purpose and belonging	
Environment		
Cultural	Norms, values, social routines, and conditions	Environmental factors
Physical	Surface, objects, buildings	
Social	Contacts with humans. Micro-direct contact e.g. relations. Meso-social groups and structures. Macro-social structures regulated by policies, organisations, institutions, e.g. conditions in society to be contain a role	
Institutional	Regulations that hindrance activities in daily life such as social patterns, organisation of power, e.g. laws, policy, budgets. And the 'invisible organisation' determines which interventions are offered	
Occupation		
Self-care	Personal activities of daily living, Looking after oneself	Activities/participation/personal factors
Productivity	Paid activities, e.g. work or studies, unpaid activities such as household chores and other instrumental activities of daily living	
Leisure	Activities that provide relaxation/sense of meaning/enjoying life	

Ethical considerations

This study was approved by the Swedish Ethical Review Authority (Dnr 2021-00715). All personal data (names, social security numbers, post codes, names of social welfare officers or relatives) were crossed out in black by the social welfare officer before being handed over to the researchers. Hence, no individual person could be linked to a specific decision.

Results

The older adults' specific reasons for applying to a nursing home are presented under three categories, each answering the underlying research question and representing three main categories, and each with several subcategories (Table 3). The subcategories present different factors described in the decisions, and some descriptions are recurring in more than one factor.

Personal factors: multiple impairments and diseases led to a feeling of insecurity and made life at home too difficult

The decisions described how personal factors contributed to a lower reasonable standard of living, such as failing cognitive functions and physical impairments that reduced independence. The experiences of failing health and functions affected the daily lives of both the applicants and their relatives. Factors affecting cognitive, physical, and affective functions fall into three subcategories.

Failing cognitive functions limited a reasonable standard of living

Some applicants suffered from cognitive impairments, which could have an acute cause (e.g. brain haemorrhage) or be a symptom of an underlying disease (e.g. Parkinson's). Other descriptions connected to impaired cognitive function were severe pain leading to reduced ability to concentrate or pharmaceutical subconsciousness causing confusion or hallucinations. With failing cognitive functions, some applicants were described by relatives or healthcare professionals as having difficulties initiating activities or having impaired executive functions. These applicants often had a relative apply for them.

Physical impairments reduced the possibility of independence

Regardless of whether a physical impairment had a sudden onset or progressed over time, a reduced ability to be independent made the applicant or people close

Table 3. Categories, and subcategories of the underlying research questions.

Category	Personal factors: multiple impairments and diseases led to a feeling of insecurity and made life at home too difficult			Environmental factors: the cultural, institutional and social environment dominated as reasons for the decision to apply			Occupational factors: personal activities of daily life had a great impact on deciding where to live and receive care	
Subcategory	Failing cognitive functions limited a reasonable standard of living	Physical impairments reduced the possibility of independence	Severe anxiety exacerbated loneliness and reduced the ability to be alone at home	Family culture determined where you should live and receive care	Social service couldn't meet the support requested or need for care in ordinary housing	When health deteriorated, the social environment become less important	The physical environment was rarely reason enough to apply	Limitations in personal activity daily life expedited the decision	Activities in productivity and leisure were described to a limited extent

to them question their future living arrangements. Examples of sudden onset were physical impairments such as stroke, cancer or heart-and-lung diseases whereas the impairments progressing over time could be a decreased level of energy or loss of muscle strength affecting lifting and walking. Common were descriptions of worsened balance, accompanied with a risk of falling (several applicants had fallen in their homes multiple times). Many of the decisions described a fear of falling and not being found, or not being able to use the PERS alarm. With physical impairment, the need for support increased and many descriptions highlighted the shortcomings of home-based care, as it does not offer support around the clock. Applicants spent most of the time alone and could not move around safely in their homes or independently perform activities of daily living (ADL), like using the bathroom.

Severe anxiety exacerbated loneliness and reduced ability to be alone at home

Severe anxiety and a desire for proximity to healthcare professionals were often given as a reason for applying to a nursing home. Many applicants wanted to live and receive care like in hospitals or short-term care facilities, which have staff around the clock. This desire was based on poor experiences of ageing in place, e.g. after a traumatic fall that resulted in hours of lying in pain, or of being treated disrespectfully by home-based care staff. This anxiety made it difficult for applicants to feel safe when alone in their homes and was manifested in frequently reaching out to relatives for companionship. For non-verbal applicants, anxiety manifested for example in motor restlessness and agitation, and co-living family members described how they could not leave the applicant alone at home. For non-mobile applicants, anxiety led to panic attacks and a fear of being left alone, because it made them vulnerable and dependent on others. Anxiety and expressions of not feeling safe in one's own home played a significant role in the decision to apply. Some applicants could still live independently and had no major need for care but applied solely because of their anxiety. The decisions described that a living arrangement such a nursing home was considered to be a solution for the feelings of anxiety and uncertainty they experienced inside.

Environmental factors: the cultural, institutional and social environment dominated as reasons for the decision to apply

The decisions described how cultural, institutional, social and physical environmental factors affected the desire to apply for a place in a nursing home and fall into four subcategories. However, physical environment was less mentioned in the decisions, and that social services and the market for alternative living arrangements for older adults gave the applicants the impression that a nursing home was the only alternative for them.

Family culture determined where you should live and receive care

In several decisions, relatives applied because the applicant could not speak for themselves due to poor health or after a life-changing injury or disease such as cancer or a stroke. The decisions contained several descriptions related to family culture. Some had family cultures in which caring for a sick family member at home was described as the norm. But when needs became extensive, relatives became tired and worried about taking care of the applicant in the right way, and applied to ensure that the applicant got the best possible care. In some cases, healthy partners wanted to apply for co-living in the nursing home so they could continue living together. Other partners described the burden of living with a person in need of extensive care and said that they could not leave their partner alone at home, which limited their own lives, or that they did not want to have staff from home-based care in their shared home. They did not want to sacrifice their own daily routines and therefore did not want the applicant to continue living at home.

Social services could not meet the requested support or need for care in ordinary housing

Most applicants had some kind of support or received care in their current home, for example home-based care. Many decisions pointed out how the current system of home-based care did not work, because it did not provide proximity to staff and support had to be scheduled, which was described as stressful (e.g. waiting for scheduled visits, not knowing who would come) by both applicants and their relatives. They described how they had familiarized themselves with different kinds of housing alternatives for older adults but made the conclusion that a nursing home was the only one providing proximity to staff around the clock. Some applicants wished to return home from a short-term care facility to extensive home-based care to see how it worked, but when they experienced it as not working, they applied for a nursing home instead. Home-based care was described as poor, based on high staff turnover and staff not speaking fluent Swedish. Often staff came unprepared for their visit, leading to the applicants being asked several times a day what they needed

help with. In addition, few had the proper education for caring for an older adult with medical needs or otherwise in poor health. Applicants with impaired cognition were described as becoming confused by staff turnover. Not uncommonly, these applicants withdrew from home-based care, which made the home situation untenable. Additionally, descriptions showed that healthcare professionals in hospitals or staff from home-based care recommended the application because of their medical condition or because the applicants' needs could not be met in their homes.

When health deteriorated, social environment become less important

Social relationships, such as good neighbours and family members who visited regularly, were thought to be the foundation of a meaningful daily life. Living in sheltered housing (a housing alternative on the open market) for older adults was described as socially optimal, because this arrangement offers shared meals and social activities, and many have a social norm of sitting outside one's apartment and conversing with passers-by. However, when an applicant's health deteriorated, it did not matter how socially available their environment was, because they became too ill to utilize it. The socially restricted situation due to Covid-19 further reduced participation in social environments, and thus social needs were no longer being met. Living together with other people and having staff around the clock were described as solutions for feelings of loneliness and isolation.

The physical environment was rarely reason enough to apply

Few descriptions were found indicating that the impetus for the application was that the older adult's home was no longer accessible. Most homes were described as functional, and many homes had undergone subsidized housing adaptation from the municipality. In some cases, the applicants needed care after extended physical impairment, such as from a stroke. In those few descriptions, the applicant's need for care was extensive and their home was no longer physically accessible. It was not unusual for an applicant to move to a nursing home from an ordinary home in another municipality to be closer to family.

Occupational factors: personal activities in daily life had a great impact on deciding where to live and receive care

The decisions described how occupations that included personal activities of daily living played a vital role in decisions about where to live and receive care, while factors related to productivity and leisure were mentioned to a lesser extent. These factors fall into two subcategories.

Limitations in personal activity in daily life expedited the decision

Mobility and self-care limitations were decisive for feeling a need for proximity to staff. The inability to be independently mobile in a safe way caused anxiety and a feeling of vulnerability, especially for those who needed to move frequently (e.g. those who made several visits to the bathroom every night). Hygiene concerns (like showering) were mentioned as activities that applicants wanted as few people as possible to help with, especially by applicants who had faced a transformative change and who suddenly need help with all ADL. As a response to their changed life situation, they often desired a move to a nursing home and wanted admission directly from hospital.

Activities in productivity and leisure were described to a limited extent

The descriptions of productivity were limited, but instrumental activities of daily life (e.g. household chores) were thought to be easier to support than personal activities of daily living. Descriptions of leisure were limited. There was information about the applicants' interests and hobbies performed earlier in life, but not how present leisure activities or the lack of them influenced the need for a nursing home.

Discussion

The aim was to study descriptions of older adults' reasons for applying to a nursing home in documents of granted nursing home decisions. The aim was underpinned with research questions that addressed each variable of CMOP-E, namely personal, environmental and occupational factors. The results showed that all factors were negatively affected and thus influenced the older adults to apply. The life situations of older adults who applied for nursing homes were complex. *Personal* factors included severe anxiety that exacerbated loneliness and reduced the ability to be alone at home, which influenced the applicants' and their relatives' perceptions of ageing in place. *Environmental* factors included family culture and social services, which framed the opportunities to receive desired care. *Occupational* factors included a reduced ability to perform ADL, which greatly influenced decisions to apply to a nursing home. Our results are congruent with

previous research [4,10] as it demonstrates how nursing home applicants have the same desire as other older adults regarding how they wish to live and receive care. However, the results also show that older adults who apply for a place in a nursing home perceive their quality of life as being negatively affected when their living situation becomes unstable. This suggests that more needs to be done by occupational therapists (OTs) working with older adults who are ageing in place. As an OT, it is easy to initially focus on occupational factors [27]. However, the results of this study emphasize the importance of also considering personal and environmental needs to better support older adults ageing in place.

To use CMOP-E has been described as a useful approach to address barriers in daily life and to identify occupational justice or social justice (19,p.211–213). Our results suggest that older adults' reasons for applying for a nursing home placement are linked to the institutional environment, which can be considered as constraints at a societal level (e.g. number of housing alternatives, limitations in proximity to home-based care, lack of self-determination regarding daily routines when home-based care is needed). This can be interpreted as a consequence of limitations in occupational justice for older adults in Swedish society. According to Hammel [28], occupational justice is the ability to engage in occupations that lead to health and well-being, which should be considered a human right. Occupational justice has also been described as including social conditions of life [29], although social conditions are often discussed in terms of social justice [30]. Social justice can itself refer to one of two things: (1) a societal right to be treated equally, or (2) the equitable distribution of societal resources.

Beginning by covering social justice, in our results under CMOP-E's category *personal factors*, decisions included descriptions of anxiety, which affected the older adult's daily life by decreased number of activities, leading to isolation in their own homes. This could be seen as a signal to occupational therapists working with an older adult, to enable occupational performance and participation in order to promote social justice. Proposed solutions have included OTs introducing social media to increase already established social connections with family and friends [31]. An example in *environmental factor* was when applicants described how they did not have the energy to utilize the social environments available around them. This kind of information could prompt an OT to remind an older adult that social participation does not have to include the actual performance of activities. Simply being close to social activities or feeling the energy from others could promote social cohesion and prevent negative thoughts [8]. OTs have the knowledge to contribute to improved opportunities for social activities by educating municipal politicians about the importance of investing in social environments and having social centres for older adults [32].

In our results, two specific aspects of occupational justice were identified, namely, occupational marginalization and occupational deprivation [33]. The first, occupational marginalization, occurs when social expectations, norms and standards prevent a person from making decisions about how to participate in occupations of daily life [34]. In our results, occupational marginalization manifested in at least three ways: (1) housing alternatives and social services limited options of how to live and receive care; (2) healthcare professionals evaluated the applicants as no longer fit to age in place and strongly recommended them to apply or applied for them; (3) relatives who did not want to live with someone who had extensive needs for home-based care applied for them as a representative. One common reason that applying relatives gave was that they thought the applicants were lonely and not safe when living alone. However, many of these applicants had been independent in their daily life, and if their feelings of loneliness or lack of security could be catered for, they could have continued ageing in place. Currently efforts in Sweden to address these issues are limited. To date, municipalities only offer the PERS alarm, a home-worn device for emergency help. Already in year 2011 such devices were evaluated to limit the users' mobility and freedom and increase their anxiety and fear [35]. Consequently, PERS alarms worsened occupational marginalization by restricting older adults' ability to make daily decisions. In our results, this was described as increasing anxiety, insecurity and isolation. Hence, a suggestion for future studies is to focus on how to meet the inner insecurity of older adults ageing in place. Through occupational therapy, the risk of negative experiences can be reduced by filling the days of older adults ageing in place with more meaningful activities. Another suggestion is to conduct studies into how OTs can be supplemented with professional support from counsellors, and if, engagement in daily activities while ageing in place can postpone the need for a nursing home admission.

The second aspect of occupational justice, occupational deprivation, occurs when a person is excluded from engagement in meaningful occupations due to external factors over which the individual does not have control [36]. In our results, occupational deprivation manifested itself in how home-based care was carried

out, especially how unsatisfactory support with self-care and mobility gave the applicants the perception that a nursing home was the only option for receiving care on their own terms. If municipalities would allow it, OTs could help prevent occupational deprivation by recognizing these occupations as crucial and use their client-centred approach to find out how an individual would prefer to be supported. Similarly, our results showed that applicants felt stuck in their homes and could not control their own out-of-home activity levels, because the support needed was late in arriving, or not scheduled to arrive for some time. These applicants felt that their repertoires of activities became too small or monotonous, which increased occupational deprivation. In both these cases – help with self-care/mobility and out-of-home activities – home-based care could be improved by educating staff about the psychological effects of occupational deprivation.

Methodological considerations

During data selection, decisions were divided into pre-and during the Covid-19 pandemic periods, assuming the pandemic might have influenced the reasons for a nursing home application. This ensured data were trustworthy and mirrored the time of data collection. However, descriptions of how the pandemic influenced the reasons for applying for a nursing home were limited in the decisions. Further in data selection, an initial sample size calculation of 400 documents followed Braun & Clarke's [23] recommendations for document analyses. However, the documents in this study proved to be so extensive and rich in information that the number of included decisions needed to be limited to make the analysis feasible. This might be seen as a limitation, but considering the rich data, and the fact that 160 documents were included in the analysis, it was judged to not influence the trustworthiness of the results. Our experiences from using Braun and Clarke's [23] recommendations can be helpful to other researchers performing document analysis concerning older adults ageing in place.

To develop the link between CMOP-E and ICF, a study-specific matrix was created [21] instead of using the matrix proposed by Townsend & Polatajko (19,p.33–36). To make this alternation strengthened the analysis, as it ensured that all authors conducted equivalent analyses. All authors had previous knowledge of CMOP-E and ICF, in addition A1 had previous experience of using the Social Service Act. A1's pre-understanding was considered positive in becoming familiarized with the documents and understanding the content from a legal point of view. On the other hand, all authors were aware that pre-understanding can affect analysis, and thus all authors were involved in the analysis to enhance trustworthiness in the analytical process. One advantage of using CMOP-E in a deductive analysis was that it provided a clear structure and highlighted difficulties on both an individual and societal level. Additionally, CMOP-E's link to occupational justice (19,p.211–213), enabled proposals for implementation based on the results of this study.

During the analysis, some limitations in the study became clear: (1) the content of the decisions is based on the social welfare officer's personal understanding and summary of an applicant's statements, and those of relatives and various healthcare personnel; (2) the documents did not systematically record who said what and differed in writing quality, depending on the social welfare officers' skills in describing a person's needs; (3) one consequence of Covid-19 might be that information found in the decisions could have been out of date if an assessment from an OT was not possible during the pandemic; (4) OT assessments were not always included in the decisions, and although a person's ability to perform ADL had often been reported in previous records, there was no information about how recent the assessments were. The OT assessments that were obtained were dominated by personal activities like mobility and self-care, and included limited information about other areas of life, especially leisure. An up-to-date, more comprehensive assessment by an OT could have given the social welfare officer a more solid basis for determining how ageing in place really was working and how daily life could be supported. In addition, it seems important that OTs are engaged earlier with a focus on preventive interventions to enable ageing in place, rather than in connection with an assessment related to a nursing home application.

Conclusion

Older adults with somatic needs apply to nursing homes for many reasons, including severe anxiety, wanting a different social context, limited independence in self-care and mobility, and pressure from relatives and healthcare professionals. Descriptions of activities in daily life were limited, especially leisure. One conclusion, and implication for practice is to further involve OTs in the evaluation of nursing home applications. They can contribute with gaining a more comprehensive basis for a decision regarding functioning in daily life including such as leisure and social activities. Additionally, OTs need to work preventively with older adults to enable ageing in place.

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ORCID

Lisa Spang http://orcid.org/0000-0002-0906-6087
Kajsa Lidström-Holmqvist http://orcid.org/0000-0002-5799-3045
Marie Holmefur http://orcid.org/0000-0001-5418-3154
Cecilia Pettersson http://orcid.org/0000-0002-4863-5844

Data availability statement

Data not available due to ethical and legal restrictions.

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