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REVIEW ARTICLE

Existential well-being for the oldest old in nursing homes: a meta-ethnography

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Abstract
Ideas of well-being in old age are often anchored in the successful ageing paradigm, foregrounding independence, activeness and autonomy. However, for those oldest old living in nursing homes, these goals are largely out of reach. In this article, we use the meta-ethnographic method to explore and reinterpret existing findings on the ways in which well-being is experienced (or not) by the oldest old in institutional care settings. We frame our findings in existential well-being theory, which understands wellbeing as a sense of 'dwelling-mobility'. Our analysis resulted in the following themes: (a) institutionalisation as both restrictive and liberating; (b) reciprocity and mattering: the importance of being seen; (c) the need for kinship and the problem of ruptured sociality; (d) rethinking agency: situated, delegated and supported; and (e) lowered expectations: receiving care is not a passive act. We conclude that while institutional care environments are not always conducive to well-being, this does not have to be so. By shifting our focus from successful ageing ideals onto relationally situated care practices, a possibility for existential well-being opens up, even in situations of decline and care dependency.

Keywords: oldest old; well-being; nursing homes; dwelling-mobility; care; successful ageing

Introduction

Well-being among older persons is an issue of increasing interest and pertinence. With a rapidly ageing global population comes an increased focus on how to age well, evidenced by the influence of the 'successful ageing' paradigm (Lamb *et al.*, 2017). This discourse typically centres on the 'younger old'. The ideals of successful ageing rarely include a nursing home, focusing instead on independence and autonomy. As care needs increase, for many oldest old a move into a nursing home may be the only viable option (Szczepura, 2011). The move is often accompanied by mixed emotions, and under any circumstance heralds a major change in the older person's life (Wiersma and Dupuis, 2010; Löfqvist *et al.*, 2013; Pocock *et al.*, 2021). In many ways, the nursing home represents the antithesis of ageing well as it is defined in many Western cultures, where becoming dependent on others is an often-dreaded fate (Agich, 2003). Despite much critique of successful ageing (Moody, 2009; Katz and Calasanti, 2015; Martinson and Berridge, 2015; Rubinstein and de Medeiros, 2015; Lamb *et al.*, 2017; Corwin, 2020), well-being in nursing homes has largely been investigated from the implicit assumptions of this paradigm. Well-being is also typically investigated as a measurable concept, *e.g.* under the quality of life concept (Bowling, 2005; Mollenkopf and Walker, 2007; Van Malderen *et al.*, 2016), as subjective well-being (*see e.g.* Shmotkin *et al.*, 2013) or as adjustment to ageing (Von Humboldt and Leal, 2015). Other approaches have considered well-being from psychological and spiritual perspectives, *e.g.* through the theory of 'gerotranscendence' (Tornstam, 1997) and 'existential beliefs' (Araújo *et al.*, 2017). A recent review approached well-being in nursing homes from the holistic concept of 'thriving' (Baxter *et al.*, 2021). However, no review to date has attempted to synthesise findings on well-being for oldest old nursing home residents through an existential well-being lens.

As the global population ages, living longer than ever before, many more people will require care in the future. It is therefore crucial that we understand the complexities of well-being in old age, and how care is experienced, to ensure that well-being and dignity are at the heart of future care solutions.

In this article, we highlight lived experiences of existential well-being among oldest old nursing home residents and the ways in which these experiences are shaped by the institutional environment. Existential well-being is a phenomenological approach that understands well-being as 'a pre-reflective experience of a sense of being deeply at home in both non-literal and literal ways' (Galvin, 2018: 2). By applying the meta-ethnographic method (Noblit and Hare, 1988) to existing literature, we interpret findings on well-being through the existential well-being framework of Galvin and Todres (2013). The 'at-homeness' of well-being makes the nursing home doubly compelling because the institution is at once home and not-home. Here, this tension serves to highlight some of the barriers to achieving well-being for oldest old nursing home residents.

Background

For a few decades now, the 'successful ageing paradigm' has been hegemonic in defining the parameters of the good life in old age (Lamb *et al.*, 2017). The basic tenets of this model are that independence, activeness, productivity and engagement should continue well beyond retirement. For many 'young old' (60+ years), these ideals are both desirable and attainable. However, this stretching out of midlife is only possible for so long. For the oldest old, usually defined as 85+ years, the ambitions of successful ageing are largely out of reach once physical and/or cognitive abilities start to decline. Advanced age brings with it a number of challenges – frailty, chronic illness, reduced mobility, disability and social vulnerabilities – that make many older people care-dependent. As such, life in the 'fourth age', as very old age is sometimes called, is in many ways construed as dichotomous to successful ageing (Gilleard and Higgs, 2010; Pickard, 2019).

Nursing homes, especially, are associated with frailty, decrepitude and abjection in the social imaginary, 'they represent a fate to be resisted, if not avoided altogether, a fate worse than death' (Higgs and Gilleard, 2021: 2, *see also* Agich, 2003). Life in a nursing home contrasts in almost all aspects with the successful ageing ideal. It connotes dependency, immobility, passivity and disengagement. These are all modes of being that do not register as conducive to happiness or successful personhood in the dominant neoliberal imaginary (Leget, 2017). It is thus necessary to probe the ways in which well-being can be fostered in circumstances that are, to many, suggestive of the unravelling of personhood (Lamb, 2014; Degnen, 2018).

Nursing homes are public or private institutions that provide 24-hour live-in care to persons, usually older, who can no longer live independently due to complex health needs, disabilities and other vulnerabilities. It is important to acknowledge that nursing home populations, staffing practices and the complexity of care offered is heterogenous across countries (Sanford *et al*., 2015). In the 1950s, British sociologist Peter Townsend conducted a large-scale study of British nursing homes, in which he found the majority to be of poor standard, resulting in an influential critique of the institutionalised care provision of the time (Townsend, 1962). In the last few decades, the culture change movement has gained pace, with a growing trend towards transforming nursing homes from an institutional medical model focused on task-oriented care to a person-centred care model (Koren, 2010; Brownie and Nancarrow, 2013; Zimmerman *et al*., 2014).

The core principle of person-centred care is to put the whole person and their quality of life at the heart of their care by empowering the resident to make their own decisions. The key words here are choice, autonomy and empowerment. The person-centred approach aligns with the values of successful ageing, and attempts, perhaps indirectly, to extend them into very old age. Nursing homes are thus moving away from the 'total institution' model (Goffman, 2017) of the past, in order to provide home-like environments that foster well-being.

Well-being for oldest old nursing home residents, however, does not necessarily follow the same contours as that which underpins the person-centred and successful ageing models. The transition from third to fourth age is marked by a deterioration in health, and therefore does not hinge inevitably on chronological age (Kafkova, 2016). Indeed, it can be said that a decrease in physical and/or cognitive well-being is one of the markers of the transition from the third to fourth age (Baltes and Smith, 2003; Gilleard and Higgs, 2011; Kafkova, 2016). This in itself produces a paradox for the potential for well-being in very old age. As Galvin (2018: 2) points out, well-being has too often been seen as an either–or antipode to suffering. Here, we aim to nuance these understandings in order to consider how well-being might be fostered *alongside* the suffering of the fourth age. Well-being is often sectioned into discrete categories of physical well-being, social well-being, emotional well-being, *etc*. The dwelling-mobility framework attempts to overcome the limitations of these distinctions by grasping the structures that make all kinds of well-being possible (Galvin, 2018). From the perspective of successful ageing, these categories have particular cultural values attached: social well-being (activeness, productivity), physical well-being (mobility), emotional well-being (independence), mental well-being (autonomy, choice). These understandings mirror a particular cultural understanding of what it means to be a person. It is, therefore, important to highlight how the ideal of successful ageing impinges on norms and beliefs around well-being in ageing. Steeped in neoliberal ideas of personhood (Lamb, 2014; Lamb *et al*., 2017; Degnen, 2018; Pickard, 2019), successful ageing stands as the pinnacle of the good life in old age and forms the backdrop against which very old age is measured. Viewed through the lens of successful ageing, the realities of very old age do not measure up well. It is important to highlight that these are cultural constructs of well-being, not objective, independently existing natural phenomena of well-being. By drawing attention to the ways in which culture shapes our understandings of well-being, we are able to open up to new possibilities which are better suited to the realities of the fourth age and its vicissitudes.

Method

The aim of this review was to explore how well-being (or its absence) is experienced by the oldest old as it is produced (or impeded) in care relations within institutional settings. For this purpose, we use meta-ethnography, an interpretive method first developed by Noblit and Hare (1988). Where other types of reviews aggregate findings, the purpose of an interpretive review is not to be exhaustive, but rather to reinterpret conceptual findings to create new insights and allow the reader to see the issue or topic from a new perspective (Noblit and Hare, 1988; Eisenhart, 1998; Campbell *et al*., 2011; France *et al*., 2014; Noblit, 2018). This is achieved by translating the studies into each other and synthesising the findings.

The method proceeds through seven iterative phases: (a) getting started (defining your topic of interest); (b) deciding what is relevant to the initial interest (the search for relevant literature); (c) reading the studies (repeated reading is required); (d) determining how the studies are related (creating a list of key 'metaphors', or concepts, from each study); (e) translating the studies into one another (the concepts from each study are then compared and mutually interpreted); (f) synthesising translations (translations are synthesised to reach new interpretations); and (g) expressing the synthesis (communicating the findings in an appropriate format to the intended audience).

The concepts may be reciprocal or refutational, meaning that the findings of each study either support or contradict those of other studies. Concepts may then be drawn into a 'line-of-argument' synthesis, where new interpretations are offered (France *et al*., 2014). The result should reveal something greater than the sum of its parts (Noblit and Hare, 1988: 28).

Eligibility criteria

With the assistance of a research librarian, a systematic literature search was conducted between August and October 2020. The following databases were searched: PubMed, Scopus, CINAHL and Sociological Abstracts. Various combinations of search terms were used (*see* Table 1).

Table 1. Search terms

Population	Interest	Context	Method
'Oldest old'	Wellbeing	Care	Ethnograph*
Octogenarian	Well-being	Care-giving	Qualitative
Nonagenarian	'Well being'	'Care giving'	Phenomenolog*
Centenarian	'Quality of life'	'Residential care'	Interpretive
'Very old'	'Good life'	'Home care'	'Lived experience'
'Fourth age'		'Nursing home'	'Life world'
'80 plus years'		'Institutional[1] care'	
		'Care dependency'	

The searches returned a total of 3,198 results; 3,125 were excluded based on title and/or abstract. Of the remaining 73 articles, 42 were excluded on full-text screening. Thirty-one studies were then subjected to a CASP (Critical Appraisal Skills Program) assessment conducted independently by EJB and MGK. Critical appraisal prior to reading the studies (the third phase) is not recommended by Noblit and Hare (1988), but we followed the recommendation of Campbell *et al.* (2011) to use it as a tool for close reading and for facilitating a discussion as to the suitability of each study within the research team. Following a comparison of CASP results, 20 studies were finally included in this review. Included studies had to deal in some way with well-being as a lived experience. For this reason, only studies with a phenomenological, hermeneutic or ethnographic methodology were included. While not essential according to Noblit and Hare (1988), selecting studies with similar methodological approaches allowed for a more even comparison. Studies had to be based on nursing homes, and they had to in some way consider the relationship between resident and care-giver from the resident's perspective. It was not always possible to find studies focused only on the oldest old, but only studies with a preponderance of older participants were included. Only studies from 2005 onwards were included in order to reflect contemporary experiences.

In addition to producing a synthesised interpretation of existing studies, the purpose of a meta-ethnography is also to make a contribution to the development of theory (Noblit, 2018; France *et al.*, 2019). Therefore, only 'conceptually rich' articles were included (France *et al.*, 2019). This means that the articles included in this review were selected for their ability to expand our understanding of how well-being for the oldest old is (not) constituted in nursing homes.

Following the selection of studies, a meta-ethnography then proceeds in a hermeneutic manner by reading and re-reading the studies multiple times, extracting the main concepts (or metaphors) and then considering the relationship between these studies. We did so first by making a list of concepts from each study, and then coding the studies in NVivo as a way of translating the studies into each other. Following this step, concepts were synthesised in a higher-order interpretation. 'Concepts' here is in line with the definition of France *et al.* (2019: 453) as something that holds 'analytical or conceptual power, unlike more descriptive themes'.

Theoretical underpinnings

In broad terms, this meta-ethnography employs a lines-of-argument approach to the synthesis of studies, which attempts to use 'theory to ferret out the unapparent import of things' both within each study and across studies in order to 'discover a whole among the parts' (Noblit and Hare, 1988: 63). An interpretive approach seeks to make the implicit explicit, by revealing taken-for-granted assumptions (Noblit, 2018). We approached the synthesis from the principle that in meta-ethnography both theory and critique are integral to the translation (Noblit, 2018; Urrieta, 2018). By way of theory, we apply Galvin and Todres' (2013) framework for existential well-being and humanising care to draw out the lived experiences of well-being as well as to understand the underlying structures of well-being. In doing so, we work from the assumption that well-being means different things to different people, but also has some common underlying features within the intertwining domains of embodiment, mood, identity, spatiality, temporality and intersubjectivity (Galvin and Todres, 2013). This is not the kind of well-being that can be measured on an objective scale. Galvin and Todres (2013) posit that the essence of well-being is a combination of a sense of (metaphorical, literal and existential) home and adventure. They term this combination 'dwelling-mobility' and argue that well-being is structured by these two modes of being. Mobility refers to a sense of adventure and possibility, the feeling that one can be called into something new. Dwelling, on the other hand, refers to what Heidegger termed *Gelassenheit* or a 'letting-be-ness', meaning that one finds peace with what is given. In dwelling there is an acceptance of what is, even of that which is painful. In this definition then, suffering does not occlude the possibility for well-being. Even in situations of misery, a possibility for well-being exists. That is to say that well-being and suffering are not polar opposites, rather they exist in flux on a continuum.

Furthermore, Galvin and Todres (2013) also posit that care practices may be either humanising or dehumanising. This means that some ways of caring have the potential to foster well-being, while other more reductionistic approaches to care may detract from well-being. To get a whole picture, then, of well-being in nursing homes, it is necessary to consider both the opportunities for dwelling-mobility, as well as the care practices in which these domains are bound up.

Results

Our findings are organised across the following five themes: (a) institutionalisation as both restrictive and liberating; (b) reciprocity and mattering: the importance of being seen; (c) the need for kinship and the problem of ruptured sociality; (d) rethinking agency: situated, delegated and supported; and (e) lowered expectations: receiving care is not a passive act. These themes represent varied but interlocking aspects of the lived experiences of existential well-being in nursing home care for the oldest old. They also highlight the ambiguity and nuance of such lived experiences, which are rarely wholly negative nor wholly positive, but complex and dynamic, and always context specific, underlining the fact that very old age, like any other lifestage, is multiple.

Table 2 gives an overview of the included studies.

Table 2. Included studies

Author	Title	Journal	Method	Country	Mean age or age range[1]
Anderberg and Berglund (2010)	Elderly persons' experiences of striving to receive care on their own terms in nursing homes	*International Journal of Nursing Practice*	Hermeneutic-phenomenological	Sweden	82
Bergland and Kirkevold (2005)	Resident–caregiver relationships and thriving among nursing home residents	*Research in Nursing and Health*	Descriptive-exploratory (social phenomenology)	Norway	65+
Bergland and Kirkevold (2006)	Thriving in nursing homes in Norway: contributing aspects described by residents	*International Journal of Nursing Studies*	Descriptive-exploratory (social phenomenology)	Norway	89
Bland (2007)	Betwixt and between: a critical ethnography of comfort in New Zealand residential aged care	*Journal of Clinical Nursing*	Critical ethnography	New Zealand	66–91
Boelsma *et al.* (2014)	'Small' things matter: residents' involvement in practice improvements in long-term care facilities	*Journal of Aging Studies*	Responsive evaluation	The Netherlands	85
Bollig *et al.* (2016)	Nothing to complain about? Residents' and relatives' views on a 'good life' and ethical challenges in nursing homes	*Nursing Ethics*	Qualitative/interpretive description	Norway	82
Caspari *et al.* (2018)	Tension between freedom and dependence – a challenge for residents who live in nursing homes	*Journal of Clinical Nursing*	Explorative and hermeneutic	Sweden, Denmark, Norway	62–103

(*Continued*)

Table 2. (*Continued.*)

Author	Title	Journal	Method	Country	Mean age or age range[1]
Franklin *et al.* (2006)	Views on dignity of elderly nursing home residents	*Nursing Ethics*	Hermeneutic	Sweden	85+
Hjaltadóttir and Gústafsdóttir (2007)	Quality of life in nursing homes: perception of physically frail elderly residents	*Scandinavian Journal of Caring Sciences*	Hermeneutic-phenomenological	Iceland	76–93
Høy *et al.* (2016)	Maintaining dignity in vulnerability: a qualitative study of the residents' perspective on dignity in nursing homes	*International Journal of Nursing Studies*	Phenomenological-hermeneutic	Sweden, Norway, Denmark	62–103
Jonas-Simpson *et al.* (2006)	The experience of being listened to: a qualitative study of older adults in long-term care settings	*Journal of Gerontological Nursing*	Qualitative descriptive method (parse)	Canada	70–90
Minney and Ranzijn (2016)	'We had a beautiful home … but I think I'm happier here': a good or better life in residential aged care	*The Gerontologist*	Interpretive-phenomenological	Australia	77–95
Mondaca *et al.* (2018)	Influencing everyday activities in a nursing home setting: a call for ethical and responsive engagement	*Nursing Inquiry*	Hermeneutic	Sweden	76–103
Nakrem *et al.* (2013)	Ambiguities: residents' experiences of 'nursing home as my home'	*International Journal of Older People Nursing*	Descriptive exploratory	Norway	75–96
Palacios-Ceña *et al.* (2014)	Non-capable residents: is the experience of dependence understood in nursing homes? A qualitative study: non-capable residents in nursing homes	*Geriatrics and Gerontology International*	Qualitative phenomenological	Spain	83

Palacios-Ceña *et al.* (2016)	Is the experience of meaningful activities understood in nursing homes? A qualitative study	*Geriatric Nursing*	Qualitative phenomenological	Spain	82
Paque *et al.* (2018)	Living in a nursing home: a phenomenological study exploring residents' loneliness and other feelings	*Scandinavian Journal of Caring Sciences*	Qualitative phenomenological	Belgium	84
Pirhonen and Pietilä (2018)	Active and non-active agents: residents' agency in assisted living	*Ageing & Society*	Ethnography	Finland	60–100
Taylor *et al.* (2014)	'I accept it [staff assistance]; no choice': an ethnographic study of residents' attitudes towards mobility within nursing homes	*International Journal of Older People Nursing*	Ethnography	Australia	86
Westin and Danielson (2007)	Encounters in Swedish nursing homes: a hermeneutic study of residents' experiences	*Journal of Advanced Nursing*	Hermeneutic	Sweden	86

Note: 1. The age range is given when the mean age is not available.

Institutionalisation as both restrictive and liberating

Institutionalisation appears as a theme to some extent across all the studies. Its impact on well-being is complex. Several studies showed the tension between the frustration of being institutionalised, on the one hand, and the relief of having care available on the other (Franklin *et al.*, 2006; Westin and Danielson, 2007; Minney and Ranzijn, 2016). This tension exemplifies the spectrum of humanising and dehumanising care, a term used by Galvin and Todres (2013) to signify that the way care is delivered can be experienced by the recipient on a range from holistic to reductionistic.

Our analysis points to a problematic we call 'failing bodies in failing systems'. This concept embodies the disparity between the needs of the declining older body and the rigidity of bureaucratic systems and can be seen across a number of studies (Hjaltadóttir and Gústafsdóttir, 2007; Anderberg and Berglund, 2010; Boelsma *et al.*, 2014; Palacios-Ceña *et al.*, 2014, 2016; Bollig *et al.*, 2016; Caspari *et al.*, 2018; Mondaca *et al.*, 2018).Nursing home systems are often ill-equipped to cope with the complex demands placed on them, because they are 'situated betwixt and between a home, hospital, hotel and hospice' (Bland, 2007: 942). The widening gap between the good intentions to care for failing bodies and the reality of the everyday practices of a failing system is also captured in the metaphor of 'craquelures' (Mondaca *et al.*, 2018). Precisely this betwixt-and-between nature of nursing homes is brought to the fore by the idea of well-being as at-homeness. While nursing homes are institutions that require some level of bureaucracy to function, they are also the *home* of their residents. If well-being is a deep sense of at-homeness, but one's literal home is in some ways alienating, then it follows that well-being is already in jeopardy from the outset.

Entering into nursing home care, residents undergo a process of resocialisation, in which they must adapt to a new environment, and learn new rules and routines. While some feel the nursing home is a relief, even an improvement on before (Nakrem *et al.*, 2013; Minney and Ranzijn, 2016), the move from the private home into the more public, shared space of a nursing home is challenging for many (Franklin *et al.*, 2006; Hjaltadóttir and Gústafsdóttir, 2007; Westin and Danielson, 2007; Anderberg and Berglund, 2010; Nakrem *et al.*, 2013; Boelsma *et al.*, 2014; Caspari *et al.*, 2018). Life in a nursing home can be very regimented and regulated (Boelsma *et al.*, 2014). Residents describe themselves as 'slaves to the routine' (Caspari *et al.*, 2018). Some feel imprisoned (Palacios-Ceña *et al.*, 2016; Caspari *et al.*, 2018), and many long for their old homes (Bland, 2007; Hjaltadóttir and Gústafsdóttir, 2007; Boelsma *et al.*, 2014; Palacios-Ceña *et al.*, 2016). This can be taken to represent a deeper longing for a sense of being-at-home in the world, or a sense of existential well-being. In a nursing home there is a risk of becoming lost in the crowd (Hjaltadóttir and Gústafsdóttir, 2007), and of being stripped of one's adult status (Palacios-Ceña *et al.*, 2016). The demand to conform to institutional life can take a toll on the residents' sense of self. When these demands become excessive it may lead to what Galvin and Todres (2013) call 'homogenization', a dehumanising aspect of care, in which the individual's sense of unique identity is diminished.

A consistent feature of institutionalisation was the tension between residents' needs for attention and the tight schedules of the staff. Residents need the attention of staff for practical assistance, but they also crave affective attention. Many of the studies (Bland, 2007; Westin and Danielson, 2007; Nakrem *et al.*, 2013; Boelsma *et al.*, 2014; Taylor *et al.*, 2014; Bollig *et al.*, 2016; Høy *et al.*, 2016; Mondaca *et al.*, 2018) make reference to the staff's lack of time, most without specifying why. Sometimes laundry took priority over a resident in pain (Mondaca *et al.*, 2018). Sometimes the system insists on written individualised care plans, even if these are rarely put into practice (Bland, 2007). The system thus enables a double failing – it forces staff to produce paperwork that ultimately does not benefit the resident, meanwhile such production reduces the ability of staff to respond to the resident in moments of need. While dehumanising care practices may lead to homogenisation of residents, this is also true of staff. Excessive administrative demands may concentrate staff energy and attention in the 'wrong' places, leading to staff disengagement (Mondaca *et al.*, 2018), and give residents the impression that staff are more interested in getting on with routine work (Westin and Danielson, 2007).

Inconsistency across staff was also considered an impediment to developing a sense of homeliness and trust because having to constantly relate to new staff members causes confusion and uncertainty (Caspari *et al.*, 2018). Beyond these issues is the sense that sometimes care staff lack either the ability or the inclination to *care*. Numerous examples of negligence appear across the studies: being berated by staff for soiling oneself (Bland, 2007), being handled in painful ways (Taylor *et al.*, 2014), having one's pants pulled down while still walking to the toilet (Bollig *et al.*, 2016). Waiting itself is a source of suffering and causes residents to lose trust in their carers (Boelsma *et al.*, 2014; Bollig *et al.*, 2016; Mondaca *et al.*, 2018; Paque *et al.*, 2018). These are examples of care failings and fall on the dehumanising end of the care spectrum, inducing in residents a sense of objectification, passivity, homogenisation, loss of meaning, dislocation and reductionist body (Galvin and Todres, 2013). In such regimes of care, well-being is impeded by the institutional gaze, which depersonalises the individual residents, reducing them to 'tasks' to be completed. Over time, residents come to embody the institutional order (Mondaca *et al.*, 2018) and they give up asking for help (Franklin *et al.*, 2006).

Reciprocity and mattering: the importance of being seen

A common theme underpinning all the included articles is the importance of being recognised as a person. Sometimes this is described as *being seen* (Franklin *et al.*, 2006; Westin and Danielson, 2007; Boelsma *et al.*, 2014; Høy *et al.*, 2016), other times it takes the form of having a voice, *being listened to* (Jonas-Simpson *et al.*, 2006). This may also be described as *mattering*. To be affirmed in the intersubjective relationship with carers makes the resident feel that they matter, that they are 'a somebody' (Westin and Danielson, 2007). The reciprocity of the intersubjective relationship – the exchange of conversation or a joke, the sharing of opinions or experiences, *e.g.* when staff share stories about their own families with residents (Bland, 2007; Westin and Danielson, 2007) – makes residents feel part of a 'fraternity' (Westin and Danielson, 2007) and is fundamental to well-being. To be given a presence in someone else's life *gives you life*. Conversely, being ignored and left to one's own devices all day makes residents feel like they do not exist (Westin and Danielson, 2007; Anderberg and Berglund, 2010; Høy *et al.*, 2016). Residents speak of feeling invisible (Franklin *et al.*, 2006; Jonas-Simpson *et al.*, 2006) or describe their nursing home experience as 'living in silence' (Franklin *et al.*, 2006).

Reciprocity in the care relation also makes it easier to 'hand oneself over to be cared for' (Anderberg and Berglund, 2010). Accepting that one is now dependent on care can be very challenging for many residents (Franklin *et al.*, 2006; Anderberg and Berglund, 2010; Caspari *et al.*, 2018; Paque *et al.*, 2018). In cultures staked on independence, becoming dependent can feel like a failing. When carers additionally treat residents with a lack of regard for the whole person, it can cause feelings of objectification (Franklin *et al.*, 2006; Caspari *et al.*, 2018). Sometimes this takes the form of ignoring the residents' needs for extended periods of time. Residents describe being left sitting in a wheelchair (Taylor *et al.*, 2014; Mondaca *et al.*, 2018), being put to bed before they are ready (Bollig *et al.*, 2016; Caspari *et al.*, 2018) and having breakfast in a wet nappy because the staff forgot to help them (Paque *et al.*, 2018). One resident feels invisible because the staff watch television during mealtimes and forget to feed her (Bollig *et al.*, 2014). Another feels that her loss of sight and hearing have made her sub-human to her carers (Franklin *et al.*, 2006). Other times it borders on physical mistreatment in the form of rough handling (Taylor *et al.*, 2014). These instances are pixels in a bigger picture of what it means to hand over one's body to institutional care. It entails a complex mix of trust, fear, humility and acceptance.

The intersubjective presence that takes place when a carer offers their full attention to a resident is critical in nursing home care, where residents are often isolated from the outside community (Nakrem *et al.*, 2013; Boelsma *et al.*, 2014; Høy *et al.*, 2016; Caspari *et al.*, 2018). Feelings of isolation and alienation must be counteracted in order to foster well-being (Galvin and Todres, 2013). One of the ways in which staff make themselves present to residents is through listening. Residents long to be 'understood on their own terms' (Anderberg and Berglund, 2010) and to be 'seen as the persons they are' (Franklin *et al.*, 2006). Having the ability to speak openly about one's experiences creates an inner sense of freedom (Caspari *et al.*, 2018), which may help to counteract the despair of having one's exterior freedoms curtailed (lack of mobility, lack of independence). Being fully present, listening to and seeing the resident as the person they are creates a reciprocal space in which dwelling-mobility can be facilitated (Galvin and Todres, 2013).

Residents who feel listened to by their carers report feelings of contentment and well-being (Jonas-Simpson *et al.*, 2006). Being listened to nurtures a sense of connection, which in turn induces a sense of mattering. Mattering is still an important source of well-being in very old age, although the shape of it may change. While some residents accept that they are no longer central members of the social world outside the nursing home (Hjaltadóttir and Gústafsdóttir, 2007; Boelsma *et al.*, 2014), for others this is difficult to come to terms with (Høy *et al.*, 2016; Paque *et al.*, 2018). Most, however, still crave connection, kinship and a sense of belonging, and direct this need towards the staff at the nursing home (Jonas-Simpson *et al.*, 2006; Hjaltadóttir and Gústafsdóttir, 2007; Westin and Danielson, 2007; Boelsma *et al.*, 2014; Minney and Ranzijn, 2016; Paque *et al.*, 2018). It is the quality of these relationships that provides life with meaning for nursing home residents (Franklin *et al.*, 2006; Paque *et al.*, 2018).

The need for kinship and the problem of ruptured sociality

While residents often crave a connection with their carers, creating bonds of kinship and community with other residents is more complicated. In most instances, residents only move into nursing homes because of extensive care needs. This can make it difficult to establish and maintain bonds. The decline of others appears as a background theme across several studies (Jonas-Simpson *et al.*, 2006; Hjaltadóttir and Gústafsdóttir, 2007; Anderberg and Berglund, 2010; Nakrem *et al.*, 2013; Palacios-Ceña *et al.*, 2014; Høy *et al.*, 2016; Paque *et al.*, 2018). Held together, however, this theme can help us foreground an important aspect of well-being in the nursing home context. Residents in these studies refer to the decrepitude of others as disturbing, unappealing, something to be avoided. Living with others in various states of physical and cognitive decline can take its toll on residents and cause them to withdraw from social interaction. Some experience the behaviours – such as messy eating, drooling, shouting and other forms of aggression or intimidation – of these co-residents as confronting and uncomfortable (Hjaltadóttir and Gústafsdóttir, 2007; Nakrem *et al.*, 2013; Paque *et al.*, 2018). Further to creating a sense of unease, the decline of others is also representative of one's own potential decline (Anderberg and Berglund, 2010). Attempts to avoid stigma may also cause residents to distance themselves from those they deem to be less capable than themselves (Palacios-Ceña *et al.*, 2014). Palacios-Ceña *et al.* (2014) found that residents construct hierarchies of sorts, drawing boundaries around those considered more or less capable. This creates an interesting dilemma for the establishment of community. Broadly speaking, inclusion is essential to well-being (Galvin and Todres, 2013). While staff encourage residents to socialise with each other in good faith, the result may be decreased well-being (Hjaltadóttir and Gústafsdóttir, 2007). For some residents, having the ability to create distance, and *ex*clude some others, is a way of exercising agency to maintain their own sense of well-being. While the nursing home is by nature a social space, the lack of meaningful engagement with fellow residents may be a source of existential loneliness, in which social relations are experienced as ruptured (Galvin and Todres, 2013).

Rethinking agency: situated, delegated and supported

The concept of agency is seen in some form across all the studies; sometimes referred to in different ways: 'self-determination' (Nakrem *et al.*, 2013; Paque *et al.*, 2018), 'freedom' (Caspari *et al.*, 2018), 'influence' (Mondaca *et al.*, 2018), 'autonomy' (Franklin *et al.*, 2006; Bland, 2007; Taylor *et al.*, 2014) and 'independence' (Nakrem *et al.*, 2013; Minney and Ranzijn, 2016). Caspari *et al.* (2018) also refer to the 'paternalism' with which residents are often treated, when they are not consulted about their preferences.

Agency is considered to be central to well-being (Galvin and Todres, 2013). Paque *et al.* (2018), for example, conclude that self-determination is key to a good life. In most of the studies, agency pertains to the individual and also interweaves with individual competence (Palacios-Ceña *et al.*, 2014) and independence (Caspari *et al.*, 2018). Becoming dependent on others for your everyday needs means relinquishing agency, often to much consternation. Agency here is commonly taken to mean that individuals act purposively to construct their own lifecourse. In other words, agency is free will, followed by deliberate action. This understanding of agency tends to preference *activity*. Caspari *et al.* (2018) distinguish between 'inner' and 'outer' freedom. Inner freedom is one of volition, the freedom to want, for example, a walk outside. The outer freedom is one of practice, the ability to act on one's wish for a walk outside. Viewed through this lens, agency in very old age may indeed be severely curtailed.

However, agency may be broadened out to a more intersubjective space, where it may arise situationally, and it may be delegated (Pirhonen and Pietilä, 2018). Delegated agency does not mean ceding agency altogether, because it is a deliberate act of trust and consent to ask another person to act on one's behalf. The delegator retains decisional agency, while the delegate executes. What distinguishes delegated agency from restricted agency is that it is voluntarily entered into. It involves an acceptance that one's abilities to act, to *do* are more limited than they used to be. Care staff must strike a balance between letting residents do what they still can and helping with what they cannot (Bergland and Kirkevold, 2006; Caspari *et al.*, 2018). Being able to *do* is a core element of finding well-being in one's identity. The identity dimension of dwelling-mobility is 'layered continuity' (Galvin and Todres, 2013). This is comprised of a sense of 'I can' (mobility) and 'I am' (dwelling). The 'I am' part of layered continuity is at its heart about ontological security. It is the feeling of *being*, not being this or that (different layers of identity constructs), but very simply just *being*. This is pertinent in very old age, when many of the layers of the identity one has constructed over the lifecourse start to fall away. The basic sense of 'I am', without having to *be something*, can be a source of comfort and well-being. Galvin and Todres (2013: 91) call it a sense of 'being at home with one's self'.

Delegated and supported agency is seen in some of the studies, *e.g.* when residents withdraw from communal to private spaces, allowing for a sense of independence in a situation otherwise characterised by dependence (Nakrem *et al.*, 2013). Other studies showed that the scope of agency needed to be broadened but was often limited by institutional routines and regulations (Boelsma *et al.*, 2014; Caspari *et al.*, 2018). For example, some residents expressed a desire for more room to negotiate the terms of their care with staff (Franklin *et al.*, 2006) or to have a say in setting the agenda (Boelsma *et al.*, 2014). Delegated agency only works when the carer accepts the delegation. Having to ask for help and not receive it is a source of frustration and makes the loss of autonomy doubly hard to bear (Paque *et al.*, 2018).

Lowered expectations: receiving care is not a passive act

As a result of the sometimes-dubious quality of care residents receive, residents simply came to expect less. Lowering expectations is in some instances described as a technique for achieving well-being (Bergland and Kirkevold, 2006; Anderberg and Berglund, 2010). One resident describes being showered, dressed and placed in the wheelchair as 'I have been so lucky' (Nakrem *et al.*, 2013).

This sentiment is echoed across several studies (Jonas-Simpson *et al*., 2006; Bland, 2007; Anderberg and Berglund, 2010; Boelsma *et al*., 2014; Taylor *et al*., 2014; Caspari *et al*., 2018), where residents express much gratitude for very simple gestures, suggesting that they do not feel deserving of, or entitled to receive, this basic level of care. Many are afraid to speak up about the things they find difficult, uncomfortable or even painful, fearful that doing so could mean falling out of favour with the nurses and receiving even less care (Bland, 2007; Anderberg and Berglund, 2010; Taylor *et al*., 2014; Bollig *et al*., 2016; Caspari *et al*., 2018; Pirhonen and Pietilä, 2018). However, there are residents who feel respected by staff even when having a bad day (Westin and Danielson, 2007). One study found that residents who asked for help risked being discriminated against not only by staff but by other residents too (Palacios-Ceña *et al*., 2014).

There is a degree of emotion management that goes into the resident–carer relationship, where residents make an effort to be likeable, to engage with the staff, to not appear bothersome or demanding (Anderberg and Berglund, 2010; Nakrem *et al*., 2013; Caspari *et al*., 2018). In other words, they undertake a transformation of self in order to become 'the good patient' (Galvin and Todres, 2013). For example, residents strive to maintain outer composure in their dealings with their carers (Anderberg and Berglund, 2010). One resident in this study describes the process of adjusting themselves to the carers, learning to read their facial expressions, figuring out what they do and do not like, so that they know what to talk about and what not to talk about. This exemplifies how receiving care is not a passive act.

Attitude as an underlying determining factor for well-being is evident across several studies (Bergland and Kirkevold, 2006; Bollig *et al*., 2016; Minney and Ranzijn, 2016; Caspari *et al*., 2018). These studies argue that the resident's attitude towards their situation, the nursing home and their interpersonal relations was the basis upon which well-being could either emerge or be vanquished. This understanding seems premised on an assumption that attitude is a choice made by the individual. According to Bergland and Kirkevold (2006), attitude precedes the intersubjective relationship, which means that the resident has already made up their mind about whether they are going to thrive before entering into the nursing home and its social relations. The findings of Mondaca *et al.* (2018), however, provide some nuance to this perspective, showing that attitudes emerge in, and are modulated through, the intersubjective encounter.

Discussion

Our findings show that the institutional nature of nursing homes poses a challenge to experiences of well-being, as regimented routines have the potential to induce dehumanising care practices. However, our findings also indicate that it does not have to be so. The structuring experience of dwelling-mobility can be engendered through humanising care practices that recognise the individual person, opens space for (intersubjective) agency, and preferences kinship and mattering over task-oriented care.

The central values of successful ageing – independence, autonomy, activeness, engagement, choice, control – are challenged in very old age, when decline often becomes inevitable and care needs take precedence (Lamb, 2014). However, as the studies included in this meta-ethnography demonstrate, these ideals still hold currency. Dependency especially is considered a defeat in hyper-individualised cultures (Agich, 2003; Leget, 2017) such as those included in this review. What we argue, through a reinterpretation of the findings, is that there is a more fundamental level at which well-being can be experienced, that does not rely on the achievement of these values. By considering well-being through the lens of existential well-being (Galvin and Todres, 2013), a more nuanced scope of well-being opens up. While successful ageing ideals continue to hold sway, what is also clear across all of the studies is the significance of safeguarding personhood in the intersubjective space. Kinship, mattering and being recognised as a person are at the very heart of well-being for the oldest old.

Lamb (2014: 42) has argued that the successful ageing model comes at the cost of not coming to 'meaningful terms with late-life changes, situations of (inter)dependence, possibilities of frailty and the condition of human transience'. This problematic is evident even in very old age, in the rejection of decline in both self and other. Thus, while healthy ageing may in itself be a noble goal, the successful ageing model curtails our ability to conceptualise well-being in frailty and serves to police the boundaries of personhood in very old age (Degnen, 2018). 'Bad' behaviours of fellow residents go beyond merely being unpleasant in the moment they occur. These residents are persons who have, to various extents, lost control of their own bodies. Symbolically, this may be interpreted as a kind of pollution of the shared environment; something to be avoided for fear of contamination (Douglas, 2003). The dulling of cognitive faculties, the leaking of bodily fluids and odours, the production of unpleasant sounds; these losses of control mark the boundaries of sociality and signify the unbecoming of the person. The 'declining other' has failed the standards for successful ageing (Lamb, 2014; Lamb *et al.*, 2017). To understand the ways in which decline is rendered meaningful, it is important to consider the ontological assumptions underpinning Western notions of personhood. The drawing of the boundary between 'healthy old age' and 'decrepit old age' here echoes the distinction between the third age and the fourth age in the literature (Laslett, 1996; Gilleard and Higgs, 2013; Kafkova, 2016; Degnen, 2018). In the social imaginary, the crossing of this boundary marks the point of no return. In this borderland, personhood is at stake, and the side that you fall on determines whether your personhood is intact or called into question (Degnen, 2018: 153).

The aversion to others in decline causes ruptured bonds of sociality that put residents at risk of alienation. When interpersonal belonging is ruptured in this way, it puts the onus on care staff to hold open an intersubjective space in which the resident can experience kinship and belonging. According to Fredriksson (1999), the presence of the nurse (or care staff) in the intersubjective relationship with the patient (or resident) can take two forms: 'being with' and 'being there'. Being there entails the nurse attending to the patient's needs. The structure of being there is that of 'question and answer' in the sense that the patient has a need and the nurse a response. In contrast, being with is grounded in reciprocity. The structure of being with is that of 'gift and invitation'. In this way of being present, the nurse (carer) offers their whole self, and if the patient accepts this gift, they reciprocate with an invitation to enter into their vulnerability. In this kind of presence, 'nurse and patient are not only present to each other as roles, but in addition are present as whole persons' (Fredriksson, 1999: 1171). This resonates with the findings of Høy *et al.* (2016), who argue that while the weakened body is a potential threat to dignity, staff who are responsive to residents' vulnerability and who enter into a mutual effort of engagement can help to uphold dignity.

At times, the staff's 'lack of will for interplay' leaves residents feeling abandoned (Anderberg and Berglund, 2010). One resident talks of the pain of being rejected by carers: 'They say to me "we cannot understand what you are saying" … and I can't understand what they have against me' (Anderberg and Berglund, 2010: 66). Residents often attempt to connect with carers but must overcome many impediments to do so. In this instance, the carers do not accept this resident's invitation to engage and do not offer the resident the gift of their attention, because they refuse to bridge the gap of the communication barrier, causing this resident to feel rejected. This sort of exclusion from interpersonal connection fosters what Galvin and Todres (2013: 105) term an 'inhospitable lack of belonging'.

Our analysis showed that residents coped with the deficits of nursing home care by lowering their expectations of life and of care. On the one hand, this can be understood as a sign of defeat and resignation, which is problematic and detrimental to the possibility of producing well-being. If a person feels unable to affect their situation, and simultaneously feels demoted to an object, it causes a sense of 'fragmented identity' (Galvin and Todres, 2013) – the antithesis of well-being. Conversely, some authors argue that lowered expectations are a prerequisite to well-being (Anderberg and Berglund, 2010). This argument is premised on the notion that life in a nursing home (and perhaps indeed very old age itself) can never be like it was before. Therefore, in order to have a sense of well-being, one has to make peace with this reality. In dwelling-mobility we find the concept of making peace with what is given, what Heidegger termed *Gelassenheit*, a letting-be-ness of that which cannot be fought anyway. But there also must be a sense of possibility. The suffering person must feel that there is also *something more*. Care staff play a vital role in the provision of this sense of possibility. Residents seek what Mondaca *et al.* (2018) call 'a place for other lifeworlds'. This can be interpreted as the 'mobility' part of dwelling-mobility. While many residents largely accept their circumstances, they also seek the possibility for 'something more', exemplified by a resident who, during a trip to the dentist, asked her carer if they could stop at a café on the way home (Mondaca *et al.*, 2018). The request was rejected, and the opportunity for creating a sense of (dwelling-)mobility was lost.

Being dependent complicates notions of agency, but it does not necessarily eliminate it. Instead, agency is enacted and negotiated in the intersubjective space, where it may be delegated (Pirhonen and Pietilä, 2018). From this perspective, the acceptance of help and care is transformed from receptive passivity into a form of agency. This is illustrated by residents striving to balance receiving care with managing as much as possible on their own (Anderberg and Berglund, 2010; Taylor *et al.*, 2014). When delegated agency is not accepted, dependence and powerlessness is amplified (Mondaca *et al.*, 2018). Carer responsiveness to residents' needs and requests for help goes a long way to producing a strong foundation from which well-being can be experienced. The meaning of freedom in very old age may also change from the freedom *to do*, to the freedom *from* obligations (Minney and Ranzijn, 2016; Caspari *et al.*, 2018). More broadly, this can be conceived as freedom to simply *be*. This is what Galvin and Todres term 'I am' in the identity dimension of dwelling-mobility.

Some of the studies propose that the residents' personal attitudes are a precursor to well-being (Bergland and Kirkevold, 2006; Bollig *et al.*, 2016; Minney and Ranzijn, 2016; Caspari *et al.*, 2018). A systematic review of quality of life in care homes (Bradshaw *et al.*, 2012) similarly concluded that a positive attitude enabled residents to adjust successfully to care homes. We would like to nuance this understanding of attitude; and suggest that attitude is not simply a matter of choice, but rather something that is produced situationally. In this understanding, attitude is not static but something more malleable, a complex interplay of agency, intersubjectivity and mood, or rather *attunement*, as well as spatial and temporal elements. Attunement, or *Befindlichkeit* as Heidegger termed it (Greaves, 2010), conditions our very possibility for experiencing (in) the world. Our moods attune us to the world and shape our experiences of the world. A phenomenological approach thus understands mood as something that is intricately bound up with our being-in-the-world. Greaves (2010: 66) describes the reciprocity between mood and circumstance aptly: 'Through my mood circumstances reveal themselves and as they reveal themselves, they affect my mood.' Furthermore, phenomenology posits that places and situations can have moods, or 'atmospheres'. Mood, then, is not only our projection on to the world, but also something that is already there. So, our attitudes are not simply choices we make about how to feel about the world. Rather, they emerge through our engagement with the world. Our moods which are bound up with our 'thrownness' make us disposed to experience our lifeworld in a particular way.

Attitude, as it is used in common parlance, insinuates an active choice, and while we can, according to Heidegger, have agentic influence on our moods, we cannot always control it. Heidegger argues that even when we master a mood, we do so only by employing a counter-mood (Greaves, 2010). Having the 'right attitude', therefore, may require persistent effort. A move into a nursing home is usually a big upheaval in a person's life. At this point, one's life can feel like it is out of one's control. In addition to the risk of simplifying the role of attitude as discussed above, the problem with focusing too intently on the attitude of the resident is that it can lead to 'individual responsibilization' (Hunt, 2018), wherein the responsibility for the resident's well-being is placed back on the individual resident themself. A lack of well-being may thus, in this interpretation, be a failure of attitude. This approach not only neglects to consider the complexity of factors producing attitude(s), but also risks absolving care systems of the responsibility to create a caring, nurturing environment, in which dwelling-mobility can be established. While adaptability may be key to a good life in nursing homes, the transition to nursing home is an often-vulnerable time and many may lack the personal resources required to produce a 'good' attitude, or they may simply refuse to lower their expectations, and instead respond with anger (Paque *et al.*, 2018). Here, anger as resistance can be seen as an act of agency. We should also be mindful that what looks like adaptability may in reality feel like resignation.

Sometimes institutional structures hamper the possibilities for establishing a nurturing environment. In such situations, care as regimented routine precludes care as responsive intersubjectivity. Wiersma and Dupuis (2010) describe how scripted care routines in nursing homes produce institutional bodies. Care encounters are focused on the physical body – the body as an object – thus marginalising the body as an experiencing self (Wiersma and Dupuis, 2010). Care relationships are shaped by the values of the organisation, which in turn mirrors the values of the broader society (Franklin *et al.*, 2006). The failures of care systems then cannot be separated from culturally constructed ideas of ageing. Taylor *et al.* (2014) suggest we move beyond the medicalised understanding of frailty, and approach it instead as an impetus to bond, engage and collaborate. Anderberg and Berglund (2010) conclude that the aim in old age care should be a 'neutral zone', where neither resident nor staff exert control on the other. What the overall findings show, however, is not that neutrality is needed, but *real* engagement, a 'being with' as the gift of attention (Fredriksson, 1999) that allows for the possibility of dwelling-mobility.

Loe (2017) suggests that instead of aiming for successful ageing for the oldest old, it would be more beneficial to strive for 'comfortable ageing', which means fostering an acceptance of care dependence, embracing vulnerability and accepting mortality. It means 'learning to *be* in a culture of doing' (Loe, 2017: 221). The results of this meta-ethnography point in a similar direction. Successful ageing in very old age is futile, but possibilities for well-being still exist.

Conclusion

In contrast to the dominant ideals of successful ageing, against which very old age in nursing homes can look like a failure, the results of this meta-ethnography show that by shifting the focus from the attainment of particular cultural values to an understanding of how the experience of well-being is structured, it is possible to gain new perspectives on well-being for the oldest old in institutional care. We suggest that instead of measuring success, what is needed is a better understanding of the existential experiences of well-being in very old age in order to foster nourishing care environments now and into the future.

Our recommendations here do not involve a systemic restructure – though this may certainly also be desirable. What we want to emphasise and encourage is more of an epistemological and ontological reflection. By rethinking very old age through the lens of dwelling-mobility, we can contest the mores of successful ageing and the decline and deficit narrative that it augurs in the transition from third to fourth age. Care practices are inextricably linked with cultural ideas around ageing and well-being. Through the dwelling-mobility lens we have offered a different perspective in which the fourth age is not the antithesis of well-being. Instead, well-being can be fostered alongside the inevitable vicissitudes of very old age.

Humanising care practices can counteract notions of unravelling personhood by opening up an existential space in which vulnerability and well-being can co-exist. Oldest old nursing home residents experience well-being when they feel seen and valued by staff, who set aside institutional routines in favour of the interpersonal encounter and who make space for intersubjective agency. Dwelling-mobility is created through little moments of connection, moments of seeing, of hearing and of being fully present to each other on a deeply human level. Institutional routines can turn persons into tasks. This is a problem of how care delivery is structured, but the formal structures of the system also become the mental structures of its workers. Fostering existential well-being cannot be done through a set of quantifiable tasks, it is accomplished through meaningful interaction. Thus, how staff attune to residents is key. But the onus is on care systems to reorient care delivery from the task management of 'being there' care to the real intersubjective engagement of 'being with' care (Fredriksson, 1999). We suggest that the lens of dwelling-mobility allows for a better understanding of the kinds of well-being experiences that are still possible in very old age.

Limitations

The reader will note that many of the studies included are from a Nordic background. This is not by design. However, we did deliberately select only studies from a Western context. This undoubtedly poses a limitation. However, to account for very varied cultural contexts in a meaningful way that avoids reductionistic stereotypes was beyond the scope of this article. Therefore, the results should be read with this in mind.

In the cultural contexts of the included studies, eldercare is largely positioned as a public responsibility. There are some exceptions, such as Spain, where care has traditionally been largely family-based, though it is increasingly moving into the public sphere. While it would be meaningful to look into the ways in which these national structures for care provision impact care delivery, it was not within the remit of this article to do so.

Only studies from 2005 onwards were included. This was a deliberate choice in order to reflect contemporary experiences. Much has changed in recent decades as new public management approaches have come to dominate care provision. Simultaneously, recent decades have seen a move to more person-centred care via the culture change movement. Including older studies could have provided historical interest but would not have reflected the constraints within which contemporary care systems operate.

Finally, this review only considered the lived experiences of nursing home residents. We are not suggesting that the problems are caused by ill intentions of care staff, but rather the pared back neoliberal systems within which care is delivered. Further research is needed to explore how care systems can be restructured to better foster dwelling-mobility for its residents.

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References

Agich G (2003) *Dependence and Autonomy in Old Age: An Ethical Framework for Long-term Care*. Cambridge: Cambridge University Press.

Anderberg P and Berglund A-L (2010) Elderly persons' experiences of striving to receive care on their own terms in nursing homes. *International Journal of Nursing Practice* **16**, 64–68.

Araújo L, Ribeiro O and Paul C (2017) The role of existential beliefs within the relation of centenarians' health and well-being. *Journal of Religion and Health* **56**, 1111–1122.

Baltes PB and Smith J (2003) New frontiers in the future of aging: from successful aging of the young old to the dilemmas of the fourth age. *Gerontology* **49**, 123–135.

Baxter R, Corneliusson L, Björk S, Kloos N and Edvardsson D (2021) A recipe for thriving in nursing homes: a meta-ethnography. *Journal of Advanced Nursing* **77**, 2680–2688.

Bergland Å and Kirkevold M (2005) Resident–caregiver relationships and thriving among nursing home residents. *Research in Nursing and Health* **28**, 365–375.

Bergland Å and Kirkevold M (2006) Thriving in nursing homes in Norway: contributing aspects described by residents. *International Journal of Nursing Studies* **43**, 681–691.

Bland M (2007) Betwixt and between: a critical ethnography of comfort in New Zealand residential aged care. *Journal of Clinical Nursing* **16**, 937–944.

Boelsma F, Baur V, Woelders S and Abma T (2014) 'Small' things matter: residents' involvement in practice improvements in long-term facilities. *Journal of Aging Studies* **31**, 45–53.

Bollig G, Gjengedal E and Rosland JH (2016) Nothing to complain about? Residents' and relatives' views on a 'good life' and ethical challenges in nursing homes. *Nursing Ethics* **23**, 142–153.

Bowling A (2005) *Ageing Well: Quality of Life in Old Age*. Maidenhead, UK: McGraw-Hill Education.

Bradshaw SA, Playford ED and Riazi A (2012) Living well in care homes: a systematic review of qualitative studies. *Age and Ageing* **41**, 429–440.

Brownie S and Nancarrow S (2013) Effects of person-centered care on residents and staff in aged-care facilities: a systematic review. *Clinical Interventions in Aging* **8**, 1–10.

Campbell R, Pound P, Morgan M, Daker-White G, Britten N, Pill R, Yardley L, Pope C and Donovan J (2011) Evaluating meta-ethnography: systematic analysis and synthesis of qualitative research. *Health Technology Assessment* **15**, 111–164.

Caspari S, Råholm M, Sæteren B, Rehnsfeldt A, Lillestø B, Lohne V, Slettebø Å, Heggestad AKT, Høy B, Lindwall L and Nåden D (2018) Tension between freedom and dependence – a challenge for residents who live in nursing homes. *Journal of Clinical Nursing* **27**, 4119–4127.

Corwin AI (2020) Care in interaction: aging, personhood, and meaningful decline. *Medical Anthropology* **39**, 638–652.

Degnen C (2018) *Cross-cultural Perspectives on Personhood and the Life Course*. New York, NY: Palgrave Macmillan.

Douglas M (2003) *Purity and Danger: An Analysis of Concept of Pollution and Taboo*. London: Routledge.

Eisenhart M (1998) On the subject of interpretive reviews. *Review of Educational Research* **68**, 391–399.

France EF, Ring N, Thomas R, Noyes J, Maxwell M and Jepson R (2014) A methodological systematic review of what's wrong with meta-ethnography reporting. *BMC Medical Research Methodology* **14**, 119.

France EF, Cunningham M, Ring N, Lewin SA and Noyes J (2019) Improving reporting of meta-ethnography: the eMERGe reporting guidance. *Psycho-Oncology* **28**, 447–458.

Franklin L-L, Ternestedt B-M and Nordenfelt L (2006) Views on dignity of elderly nursing home residents. *Nursing Ethics* **13**, 130–146.

Fredriksson L (1999) Modes of relating in a caring conversation: a research synthesis on presence, touch and listening. *Journal of Advanced Nursing* **30**, 1167–1176.

Galvin K (2018) Introduction. In Galvin K (ed.), *Routledge Handbook of Wellbeing*. Abingdon, UK: Routledge, pp. 1–13.

Galvin K and Todres L (2013) *Caring and Well-being: A Lifeworld Approach*. New York, NY: Routledge.

Gilleard C and Higgs P (2010) Aging without agency: theorizing the fourth age. *Aging & Mental Health* **14**, 121–128.

Gilleard C and Higgs P (2011) Frailty, disability and old age: a re-appraisal. *Health* **15**, 475–490.

Gilleard C and Higgs P (2013) The fourth age and the concept of a 'social imaginary': a theoretical excursus. *Journal of Aging Studies* **27**, 368–376.

Goffman E (2017) *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates/Erving Goffman; With a New Introduction by William B. Helmreich*. New York, NY: Routledge.

Greaves T (2010) *Starting with Heidegger*. London: Bloomsbury Publishing.

Higgs P and Gilleard C (2021) Fourth ageism: real and imaginary old age. *Societies* **11**, 12.

Hjaltadóttir I and Gústafsdóttir M (2007) Quality of life in nursing homes: perception of physically frail elderly residents. *Scandinavian Journal of Caring Sciences* **21**, 48–55.

Høy B, Lillestø B, Slettebø Å, Sæteren B, Heggestad AKT, Caspari S, Aasgaard T, Lohne V, Rehnsfeldt A, Råholm M-B, Lindwall L and Nåden D (2016) Maintaining dignity in vulnerability: a qualitative study of the residents' perspective on dignity in nursing homes. *International Journal of Nursing Studies* **60**, 91–98.

Hunt A (2018) Risk and moralization in everyday life. In Hunt A, Doyle A and Ericson D (eds), *Risk and Morality*. Toronto: University of Toronto Press, pp. 165–192.

Jonas-Simpson C, Mitchell GJ, Fisher A, Jones G and Linscott J (2006) The experience of being listened to: a qualitative study of older adults in long-term care settings. *Journal of Gerontological Nursing* **32**, 46–53.

Kafkova MP (2016) The 'real' old age and the transition between the third and fourth age. *Sociológia* **48**, 622–640.

Katz S and Calasanti T (2015) Critical perspectives on successful aging: does it 'appeal more than it illuminates'? *The Gerontologist* **55**, 26–33.

Koren MJ (2010) Person-centered care for nursing home residents: the culture-change movement. *Health Affairs* **29**, 312–317.

Lamb S (2014) Permanent personhood or meaningful decline: toward a critical anthropology of successful aging. *Journal of Aging Studies* **29**, 41–52.

Lamb S, Robbins-Ruszkowski J and Corwin AI (2017) Introduction: Successful ageing as a twenty-first-century obsession. In Lamb S, Robbins-Ruszkowski J and Corwin AI (eds), *Successful Aging as a Contemporary Obsession: Global Perspectives*. New Brunswick, NJ: Rutgers University Press, pp. 1–23.

Laslett P (1996) *A Fresh Map of Life: The Emergence of the Third Age*. Cambridge, MA: Harvard University Press.

Leget C (2017) *Art of Living, Art of Dying: Spiritual Care for a Good Death*. London: Jessica Kingsley Publishers.

Loe M (2017) Comfortable Aging: Lessons for Living from Eighty-Five and Beyond. In Lamb S, Robbins-Ruszkowski J and Corwin AI (eds), *Successful Aging as a Contemporary Obsession*. New Brunswick, NJ: Rutgers University Press, pp. 218–229.

Löfqvist C, Granbom M, Himmelsbach I, Iwarsson S, Oswald F and Haak M (2013) Voices on relocation and aging in place in very old age – a complex and ambivalent matter. *The Gerontologist* **53**, 919–927.

Martinson M and Berridge C (2015) Successful aging and its discontents: a systematic review of the social gerontology literature. *The Gerontologist* **55**, 58–69.

Minney MJ and Ranzijn R (2016) 'We had a beautiful home … but I think I'm happier here': a good or better life in residential aged care. *The Gerontologist* **56**, 919–927.

Mollenkopf H and Walker A (eds) (2007) *Quality of Life in Old Age: International and Multi-disciplinary Perspectives* (Social Indicators Research Series, Vol. 31). Dordrecht, The Netherlands: Springer.

Mondaca M, Josephsson S, Katz A and Rosenberg L (2018) Influencing everyday activities in a nursing home setting: a call for ethical and responsive engagement. *Nursing Inquiry* **25**, e12217.

Moody H (2009) From successful ageing to conscious ageing. In Sokolovsky J (ed.), *The Cultural Context of Ageing: Worldwide Perspectives*. Westport, CT: Praeger, pp. 67–76.

Nakrem S, Vinsnes AG, Harkless GE, Paulsen B and Seim A (2013) Ambiguities: residents' experience of 'nursing home as my home'. *International Journal of Older People Nursing* **8**, 216–225.

Noblit GW (2018) Meta-ethnography: adaptation and return. In Urrieta L and Noblit GW (eds), *Cultural Constructions of Identity: Meta-ethnography and Theory*. Oxford: Oxford University Press, pp. 34–50.

Noblit GW and Hare RD (1988) *Meta-ethnography: Synthesizing Qualitative Studies*. Los Angeles, CA: Sage.

Palacios-Ceña D, Gómez-Calero C, Cachón-Pérez JM, Brea-Rivero M, Gómez-Pérez D and Fernández-de-las-Peñas C (2014) Non-capable residents: is the experience of dependence understood in nursing homes? A qualitative study: non-capable residents in nursing homes. *Geriatrics and Gerontology International* **14**, 212–219.

Palacios-Ceña D, Gómez-Calero C, Cachón-Pérez JM, Velarde-García JF, Martínez-Piedrola R and Pérez-De-Heredia M (2016) Is the experience of meaningful activities understood in nursing homes? A qualitative study. *Geriatric Nursing* **37**, 110–115.

Paque K, Bastiaens H, Van Bogaert P and Dilles T (2018) Living in a nursing home: a phenomenological study exploring residents' loneliness and other feelings. *Scandinavian Journal of Caring Sciences* **32**, 1477–1484.

Pickard S (2019) Old age and the neoliberal life course. In Clack B and Paule M (eds), *Interrogating the Neoliberal Lifecycle: The Limits of Success*. Cham, Switzerland: Springer International Publishing, pp. 215–234.

Pirhonen J and Pietilä I (2018) Active and non-active agents: residents' agency in assisted living. *Ageing & Society* **38**, 19–36.

Pocock LV, MacKichan F, Deibel F, Mills A and Wye L (2021) Stories from the fourth age: autonomy and the lives of older care home residents. *Ageing & Society* **41**, 1637–1650.

Rubinstein RL and de Medeiros K (2015) 'Successful aging', gerontological theory and neoliberalism: a qualitative critique. *The Gerontologist* **55**, 34–42.

Sanford AM, Orrell M, Tolson D, Abbatecola AM, Arai H, Bauer JM, Cruz-Jentoft AJ, Dong B, Ga H, Goel A, Hajjar R, Holmerova I, Katz PR, Koopmans RTCM, Rolland Y, Visvanathan R, Woo J, Morley JE and Vellas B (2015) An international definition for 'nursing home'. *Journal of the American Medical Directors Association* **16**, 181–184.

Shmotkin D, Eyal N, Shorek A, Shrira A and Blumstein T (2013) The prediction of subjective wellness among the old-old: implications for the 'fourth-age' conception. *Journals of Gerontology: Series B* **69**, 719–729.

Szczepura A (2011) Residential and nursing homes: how can they meet the challenge of an aging population? *Aging Health* **7**, 877–887.

Taylor J, Sims J and Haines TP (2014) 'I accept it [staff assistance]; no choice': an ethnographic study of residents' attitudes towards mobility within nursing homes. *International Journal of Older People Nursing* **9**, 258–268.

Tornstam L (1997) Gerotranscendence: the contemplative dimension of aging. *Journal of Aging Studies* **11**, 143–154.

Townsend P (1962) *The Last Refuge: A Survey of Residential Institutions and Homes for the Aged in England and Wales*. London: Routledge.

Urrieta L (2018) Cultural identity, theory and education: what we have learned about ourselves and others. In Urrieta L and Noblit GW (eds), *Cultural Constructions of Identity: Meta-ethnography and Theory*. Oxford: Oxford University Press, pp. 1–33.

Van Malderen, L, De Vriendt P, Mets T and Gorus E (2016) Active ageing within the nursing home: a study in Flanders, Belgium. *European Journal of Ageing* **13**, 219–230.

Von Humboldt, S and Leal I (2015) The old and the oldest-old: do they have different perspectives on adjustment to aging? *International Journal of Gerontology* **9**, 156–160.

Westin L and Danielson E (2007) Encounters in Swedish nursing homes: a hermeneutic study of residents' experiences. *Journal of Advanced Nursing* **60**, 172–180.

Wiersma E and Dupuis SL (2010) Becoming institutional bodies: socialization into a long-term care home. *Journal of Aging Studies* **24**, 278–291.

Zimmerman S, Shier V and Saliba D (2014) Transforming nursing home culture: evidence for practice and policy. *The Gerontologist* **54**, S1–S5.

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