

Forecasting the ward climate: a study from a dementia care unit

David Edvardsson, Per-Olof Sandman and Birgit Rasmussen

Aims and objectives. This article presents findings from a study aiming to explore the psychosocial climate and its influence on the well-being of people with dementia in a psycho-geriatric hospital unit.

Background. Environmental influence in dementia is well explored in relation to the physical environment; however, few studies have explored the psychosocial environment and its influence on well-being.

Design. The study had a grounded theory design.

Methods. Participant observations were conducted in a psycho-geriatric ward for assessment and treatment of people with dementia in Sweden ($n = 36$ hours). Data were collected and analysed in a dialectical fashion using the principles of grounded theory methodology.

Results. The basic social process that best accounted for the variation in the psychosocial climate and well-being of patients at the unit was 'staff presence or absence', conceptualised as the core category. Three categories emerged in relation to the core category; 'sharing place and moment', 'sharing place but not moment' and 'sharing neither place nor moment'.

Conclusions. Staff were catalysts for the psychosocial climate and when being present and engaged they could create a climate interpreted as at-homeness which supported patient well-being. When being absent, the climate quickly became anxious and this facilitated patient ill-being. To provide quality care for people with dementia staff need to be aware of their role in setting the emotional tone of the psychosocial climate and also that this emotional tone significantly influences patient well-being.

Relevance to clinical practice. The findings are clinically relevant and can be operationalised and applied in clinical practice. Awareness of the intimate connection between staff presence and absence, the psychosocial climate and patient well-being highlights an ethical responsibility to question: routines that promote staff absence; a culture of merely 'doing for'; and nursing tasks which involve a minimum of staff-patient interaction. The findings have implications for managers as well as for clinical staff.

Key words: Alzheimer's disease, dementia, environment, nursing, presence, psychosocial

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Introduction

The importance of the surrounding environment for patients' experiences of nursing care is well described in the literature, for example the influence of nature and the physical environment on interaction, well-being and reduction of

suffering (Day *et al.* 2000, Fawcett 2005, Edvardsson *et al.* 2006). In dementia care contexts, research into environmental issues in relation to well-being has mostly focused on identifying and designing supportive physical environments. The psychosocial climate has remained largely unexplored even though the psychosocial climate has been described as

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important for the well-being of people with dementia (Werezak & Morgan 2003). The aim of this study was to explore the psychosocial climate and its influence on the well-being of people with dementia in a psycho-geriatric unit.

Background

Environmental influence in the care of people with dementia has been fairly well explored, even though most studies have focused on how aspects of the physical environment impact on the well-being for people with dementia. A review of 70 studies between 1981–1995 into the physical design of dementia care environments suggested that: small size with non-institutional design; accessible outdoor areas; and moderate levels of environmental stimulation, are beneficial for people with dementia (Day *et al.* 2000). Furthermore, it has been described how homelikeness and symbols for way finding can promote adequate behaviour and feelings of safety and at-homeness among residents with dementia (Diaz Moore 1999, McAllister & Silverman 1999, Morgan & Stewart 1999, Zingmark *et al.* 2002, Ziesel *et al.* 2003). Other studies indicate that the psychosocial environment, the ‘atmosphere’ or ‘climate’ of a place, also contribute to facilitate experiences of ill- or well-being among recipients of care in different health care environments (Edvardsson & Street 2007, Rasmussen & Edvardsson 2007, Edvardsson 2008). A supportive psychosocial ward climate has been conceptualised as containing: a calm pace, a shared philosophy of care, possibilities of creating and maintaining social relations, available and trustworthy staff, a willingness to serve and a welcoming (Edvardsson *et al.* 2005). Furthermore, it has been described that the psychosocial climate can influence experiences of both at-homeness and homelessness in dementia care (Zingmark *et al.* 1995) and palliative care (Rasmussen & Edvardsson 2007). At-homeness is commonly used as an existential concept to describe experiences of being fundamentally safe and secure and experiencing connectedness to oneself, significant others, significant things and place. Homelessness is described as the existential antonym to the concept of at-homeness and refers to experiences of being displaced, unsafe, lost and alienated both from the preferred self and from the place, others and things (Zingmark *et al.* 1995, Rasmussen & Edvardsson 2007).

Norberg (1998) illustrated the importance of the climate for well-being for people with dementia by arguing that emotional interpretations of settings and situations are more immediately available than cognitive interpretations for people with dementia. This means that when it is difficult

to understand the surroundings due to diminished cognitive abilities, people with dementia are left relying on emotional perceptions of the environment. In addition, it has been shown that the feeling of emotion can endure beyond the memory of the event that initially triggered the emotion for people with amnesia (Feinstein *et al.* 2010). Thus, if the well-being of people with dementia is influenced by emotional interpretations of the environment, it becomes important to further understand how the emotional tone of the climate is created. Furthermore, interviews with experienced dementia care staff illustrate that best practice dementia care is described to involve being a step ahead, being close and creating a calm and positive atmosphere (Edberg & Edfors 2008). However, there is an absence of studies describing how such a positive psychosocial climate is created in dementia care settings and also how such climate can influence well-being for people with dementia. This article reports a study aiming to explore the psychosocial climate and its influence on the well-being of people with dementia in a psycho-geriatric unit.

Method

Context and participants

Participant observations were conducted in a psycho-geriatric ward that undertook assessment and treatment of people with moderate to severe dementia. The ward was located in a university hospital in Sweden and had 24 beds divided into three units with eight residents each. Each unit comprised a door from the common area that led into a corridor with patient rooms on each side. At the end of the corridors there was an open day room and also a dining room that was kept locked unless dinner was served. The unit admitted people that had exhibited escalating behavioural and psychological symptoms of dementia that required specialist evaluation and treatment. The mean length of stay in the units was 37 days. The nurse–patient ratio was 1:1 and the most common patient diagnoses were Alzheimer’s disease, vascular dementia and Lewy–Body dementia.

Data collection and analysis

The study had a grounded theory design where participant observations were employed as method for data collection (Polit & Beck 2008). Pairs of two observers undertook the observations simultaneously, to cover the whole unit. The observations were participatory in that observers aimed to immerse in life at the unit from patients’ perspectives and thus participated in various everyday activities at the unit

such as watching television in the dining room, drinking coffee with patients and spent time in communal areas with patients when there was a lack of activities happening. The observers took in-the-moment notes and recurrently withdrew to record: how the psychosocial climate was characterised; what seemed to contribute most to setting the emotional tone; how it was maintained; and what could explain changes in the emotional tone. The observations included visual descriptions of what happened at the unit such as the behaviour and interaction of staff, patients and family members and also sensory data such as the emotional tone of the climate as experienced by the observers. Observations were documented with pen and paper in the form of field notes and memos during sessions. After each observation session, the field notes and memos were documented in a protocol consisting of two parts; one descriptive and one reflective. The descriptive protocol consisted of pure descriptions for example of what happened, what was said, who were involved, where it happened, what it led to and expressions of emotions. The expressions of emotions were interpreted as signs of ill- or well-being depending on the positive or negative quality of the emotions expressed. The reflective protocol consisted for example of interpretations such as antecedents, consequences and meanings of interaction and behaviour, other reflections and ideas for further observations. In total, data consisted of 36 hours of detailed observations.

Data were collected and analysed in a dialectical fashion according to the principles of grounded theory methodology (Glaser & Strauss 1967, Glaser 1978). The analytic process of this study involved labelling the data with conceptual codes close to, or derived from, the empirical material. This meant that the initial conceptualisation of data used less abstract concepts (codes) derived direct from, or close to, the observation documentation (often referred to as *in vivo* codes in interview studies – cf. Glaser & Strauss 1967). These codes were then compared for similarities and differences and codes with shared meaning were grouped together and conceptually raised to categories that could describe the meaning of the codes on a higher level of abstraction. Concretely, this process meant that the authors jointly read the observation protocols and all data indicated that the climate and well-being of patients at the unit was largely influenced by the extent to which staff were present or absent with patients, which then were used as the core category. Once the core category was discovered, coding became more theoretical to link categories to the core category. Theoretical coding meant trying to explicate from data what and how codes and concepts were interpreted to be related to staff presence and absence, to explicate differences and relation-

ships between categories and finally to integrate categories with the core category.

Ethical considerations

The study was approved by the regional ethics committee Umeå, Sweden, by the division for medical research (04–151 M) and by both the head of the geriatric clinic and the head of the psycho-geriatric unit. All staff and patients were told about the purpose and method of the study, that participation was voluntary and that their contributions would be kept confidential and unidentifiable in the final report. Significant others received the same information both orally and in writing and written informed consent was established from significant others.

Results

The main finding of this study was that different modes of staff presence or absence were most influential in creating the overall psychosocial climate at the unit, which in turn influenced patient well-being. The staff were identified as catalysts for the climate at the unit and the emotional tone was largely set by staff, which meant that if staff laughed and in other ways communicated a joyful climate, this was picked up by patients who also could laugh or seem to become at ease. The opposite was also true, if staff were absent and thereby did not set the emotional tone this was left to individual patients, which often meant that as soon one person started to wander, shout or ask for help, this emotional tone of anguish was picked up by other patients who also started to express ill-being.

When staff were fully present with patients, the climate was often characterised as a climate of at-homeness where patients expressed signs of well-being such as being at ease, contented, smiling and/or laughing. However, the climate could transform almost instantly when staff left the unit to become a climate of homelessness where patients started to express anxious behaviours, wandering and verbally disruptive behaviours. Thus, the basic social process in the ward that best could account for the variation in the psychosocial climate and well-being of patients at the unit was ‘experiencing staff presence or absence’ and this was used as the core category. We discovered three categories in relation to the core category, ‘sharing place and moment’, ‘sharing place but not moment’, ‘sharing neither place nor moment’ and these are presented below. The presentation of categories is organised as follows: firstly, a description of each category is provided, secondly, data examples of each category are presented and, finally, the consequences on

Table 1 Categories describing the basic social process staff presence or absence, and consequences for patient outcomes and psychosocial climate

Category	Patient outcomes	Psychosocial climate
Sharing place and moment	Signs of well-being	A climate of at-homeness
Sharing place but not moment	Balancing between ill- and well-being	A climate of volatility
Sharing neither place nor moment	Signs of ill-being	A climate of homelessness

patient outcome and the psychosocial climate are described (Table 1).

Sharing place and moment

In a context of sharing place and moment, staff were interpreted as being fully present and available for patients and included various observations of staff involving in and connecting to patients at the unit, as opposed to conduct task oriented interactions. Sharing place and moment was characterised by staff actions such as: involving patients in meaningful ways in tasks that had to be done; socially dining with patients; small talking with them in the day room; jointly performing different non-medicalised activities; or in other ways going beyond routines to make the content of the day mean a little extra for patients. The baseline activities at the ward consisted mostly of routine based medical tasks and the category sharing place and moment was observed when staff initiated different forms of leisure activities involving the patients.

The following field note exemplifies a typical observation of sharing place and moment and illuminates how, in a context of sharing place and moment, staff were observed to make efforts to confirm the patients, see them, welcome them and participating in their everyday life at the ward:

A staff member was walking slowly down the corridor, stopped and got down on her knees by a lady in a corridor chair, telling her how beautiful she looked, acknowledged her jewellery, and said that her dress was one worthy of royalties. The staff member gently took the lady by the arm and asked if she could escort her to the day room to see if there were any exciting activities going on there. The little lady shone like the sun and walked happily with the staff member down the corridor and ended up small talking with the rest of the patients in the day room. (Field note no. 17, Tuesday 09.45, Corridor)

Staff were setting the emotional tone in the setting by their way of being and this were observed to influence the patients strongly. Another example of sharing place and moment is presented below and this is intended to illuminate how sharing place and moment created a climate of at-homeness where patients expressed well-being:

There were five patients sitting in the day room and one staff member was dressing the hair of one woman in the middle of the room. While hair dressing, the staff member commented how great the woman's hair looked and said to her that she was now becoming even more beautiful if at all this was possible. The staff member involved all of the five patients in the day room in the activity, by talking to them interchangeably – each in a personalised way, asking for advice, comments and suggestions. It was a moment when she created a homely atmosphere through seeing, communicating and involving all persons present in the room at the same time. All of the patients present in the room expressed appreciation, interest and joy. (Field note no. 19, Friday 14.15, Day room)

Sharing place and moment had observable consequences for patients at the unit. In a context of sharing place and moment, we observed few expressions of anxious behaviour for example as wandering, yelling or rummaging in patients. Signs of wellbeing such as smiles and laughter were recurrently observed and the patients seemed to be safe and secure by this form of presence of staff. Also, something happened to the climate of the unit in a context of sharing place and moment, the emotional tone was conceptualised as a climate of at-homeness; it was mostly joyful and relaxed, with laughter, social interactions and attentive listening. At these instances the atmosphere could be described as one of home, not home as a place, but rather home as an experience or feeling of being safe, connected and welcome.

Sharing place but not moment

In a context of sharing place but not moment, staff were interpreted as being physically present but not really available for patients. Observational data indicated that staff often were present at the unit but were occupied with tasks or procedures, for example revising medical lists, preparing medications and meals, cleaning, performing nursing documentation and/or having discussions amongst themselves. At these instances, staff were interpreted as being more or less task focused and thereby unavailable for interactions with patients. We observed that even though staff shared physical space with patients, at times they seemed to be in different worlds – the world of staff and the world of patients. Some

observations included staff talking amongst themselves while sharing physical space with patients without involving them into the conversations, or even ignoring patients that tried to participate in staff conversations. Other observations included staff passing by patients in the corridor without saying hello or taking notice of the person. In a context of sharing place but not moment, the role of staff could be described as being more of supervising than of participatory character, as staff were often seen interacting among themselves and patients were left interacting with each other or having nothing to do.

In a context of sharing place but not moment, the well-being of patients was not actively attended to by staff but left to chance. This did not mean that patients were observed expressing only signs of ill-being, patients were often also observed as being contented by watching the actions and interactions among staff. However, depending on unfolding situations, the mood and state of patients could become either negative or positive. On the negative side, we observed several situations where patients were explicitly excluded from the social community of staff for example by being completely ignored and marginalised by staff. In these instances, negative consequences such as anger, aggression and verbally disruptive behaviour were observed. The following field note is an example of how one of the patients was rejected from participating in a situation, with agitated behaviour as a consequence that negatively influenced the whole unit and evoked high levels of anxiety among fellow patients:

All staff from the unit were together in the staff room for a meeting. One of the patients started to enter the room with slightly agitated questions of why he needed to be at the unit. He was prevented to come in to the room by staff, saying that they now were in the middle of a meeting and that they would attend to him when this was over. He was escorted out from the room and I could hear him loudly screaming and cursing staff as he walked away from the room, upsetting fellow patients who also started to wander and express anxiety. (Field note no. 6, Wednesday 09.45, Staff room)

On the positive side, in a context of sharing place but not moment, patients were observed interacting with each other, watching staff and/or television, or sleeping in the day room and thus expressing some level of comfort. The following observation is intended to illuminate how the joy expressed between staff influenced patients even if they were not actively involved in the conversation:

There were five patients at one table having breakfast and two members of staff and one patient having breakfast at another table. Another member of staff entered the room and placed herself at the

table of staff. Staff members talked about the morning work and their free time without involving the patient at the table in the conversation. They were having breakfast together with the patients but merely sat next to the patients and talked amongst themselves. The opportunity for interaction with patients was not used and patients were not involved into the conversations. They seemed to be in different worlds even if they shared the same physical space – the world of staff and the world of patients. However, the climate was cheerful since the laughter among staff transmitted over to patients even though patients were not involved in the conversations. (Field note no. 12, Wednesday 13.45, Dining room)

The climate of the unit in a context of sharing place but not moment was conceptualised as a climate of volatility; it was neither inclusive nor exclusive, not cheerful or chaotic, but depending on unfolding situations it could change rather quickly to become a climate of at-homeness or a climate of homelessness.

Sharing neither place nor moment

In a context of sharing neither place nor moment, staff were observed as being physically absent from patients for example when being away at coffee breaks or being occupied at handovers. Sharing neither place nor moment was observed when staff became absent and unavailable for patients. Several situations were observed when staff were not physically present at the unit and, the patients were alone and unattended for. The patients could be by themselves for up to 45 minutes.

Sharing neither place nor moment had consequences for patients in the unit. Patients often sat in the day room watching television or sleeping. However, if one patient became anxious, this feeling could transfer to other patients. When staff were absent, it did not take long before the general anxiety levels rose among patients. If someone started walking, screaming or rummaging, it would not take long before most patients at the unit exhibited these behaviours and the level of anxiety collectively escalated:

Staff have withdrawn from the ward to have handover. Soon after they left, one of the patients started walking around looking for staff and rather soon another one accompanied and yet another one. It did not take long before most all patients were wandering anxiously around the unit to go home, to the bus stop, to the train, or to meet their mother, interpreted as looking for staff and the safety they could facilitate. The situation soon became more or less out of control as patients seemed not to know what to do or where to be when staff were absent, for example what to do if a fellow patient began to express anxiety. (Field note no. 24, Thursday 13.00, Day room)

Sharing neither place nor moment also meant that basic human needs such as hunger, cold, elimination and loneliness sometimes remained unmet among patients. The subtle initial expression of emerging needs were not picked up by staff as they were absent and the expression of unmet needs could escalate to become behavioural alterations as the need remained unsatisfied. When staff finally came about, they were observed to interpret the behaviour as 'disruptive' or 'disturbing' as they lacked the initial interpretative cues that could explain the behaviour. As a consequence, care became very much reactive, as staff had to come up with acute solutions to full-blown situations for which they lacked the insight and an interpretative framework. The staff were rarely observed to work proactively to satisfy the need of patients and thereby avoid the re-occurrence of difficult situations. The situation of Ralph as described below illustrates this consequence of sharing neither place nor moment:

Today Ralph sat strapped to the chair in the day room and no staff member was present. He started to say in a low voice that he needed to go to the bathroom, but no one took notice of his situation. Ralph seemed uncomfortable and tried to get up from the chair, however the belt in his groin inescapably held him down. Ralph searched the belt for an opening device and became increasingly agitated as he failed to find any. Ralph's uneasiness increased as he struggled with the restraining belt with escalating force and the chair would have fallen over if it hadn't been bolted to the wall. He began saying that he would cut himself loose, only he cannot remember where placing the knife and he starts searching the proximities for a knife. When failing to find a knife, Ralph began yelling for one. Staff members were still absent. Ralph's behaviour escalated, his anxiety raised and he kept yelling out for a knife with an increasingly loud voice. This emotional tone transmitted to other patients, who became worried and some even tried to help Ralph getting out of the chair. Eventually staff came by and removed Ralph from the day room. (Field note no. 1, Tuesday 09.00, Day room)

As staff were interpreted as being catalysts of the atmosphere at the unit, the whole atmosphere became increasingly anxious and tense when they withdrew. The atmosphere transformed into an atmosphere of homelessness where patients seemed abandoned and lost and anxious behaviours were frequently observed.

Discussion

The aim of this study was to explore the psychosocial climate and its influence on the well-being of people with dementia at a psycho-geriatric unit. The climate of dementia care settings has previously been described as important but there have

been few studies conducted in this area; this study contributes to the current knowledge base in dementia care. Two main understandings emerged from the study. Firstly, it highlights the crucial role of staff in the creation and maintenance of a positive climate with their presence, their doing and their being. Secondly, this study reiterates the point that the emotional feeling tone of the psychosocial climate is very influential on and important for, the well-being of people with dementia (Feinstein *et al.* 2010).

Best practice care of people with dementia has been described to consist of creating a calm and positive atmosphere, being close and a step ahead (Edberg & Edfors 2008). This study confirms these aspects and further delineates the necessity of staff presence in creating a positive atmosphere and contributes to the knowledge of how the psychosocial climate influences well-being in people with dementia. Also, it describes how staff can be proactive and avoid escalating behaviours and confrontations by sharing place and moment, a feature Edberg and Edfors (2008) conceptualised as being close and a step ahead. The aspect of being close emerged in this study as a prerequisite for being a step ahead. If staff were not close, they would lack the understandings necessary for being a step ahead. Rather, as a consequence of not being close, staff were interpretatively lagging behind and both the quality of care, the psychosocial climate and well-being of the patients with dementia would suffer.

Our findings suggest that the climate can support experiences of at-homeness in dementia care settings. However, the descriptive concept homelike, often used to describe ideal dementia care environments and the existential concept of at-homeness are at times used somewhat indiscriminately (e.g. Rytterström *et al.* 2009). One essential difference between the two concepts of 'homelike' and 'home' is that even if health care settings are homelike (descriptive), they do not necessarily facilitate experiences of being at home (existential) (Zingmark *et al.* 2002, Edvardsson *et al.* 2005). In this study, even though the environmental qualities of the settings were rather institutional, the psychosocial climate could be one of home and thus this did not refer to home as a place, but rather home as an experience of being safe, connected and welcome.

Zingmark *et al.* (2002) described how the good care involved being relationship-centred and doing things together with patients and how this could promote experiences of at-homeness in people with dementia. This study supports those understandings and adds insight into how such closeness, presence and involvement in activities is needed to create and maintain an atmosphere promoting well-being in patients. It is well established that good

quality residential care for people with dementia to a large extent is based on meaningful occupation, interaction and activity. This study was conducted in a traditional hospital unit in a university hospital. It seems reasonable to interpret the findings to indicate that in more 'medicalised' cultures such as university hospitals, good care might be conceptualised more as 'doing for' aspects of care such as observation, treatment allocation and evaluation and not so much on 'being with' aspects of care such as sharing place and moment, significant occupation and a meaningful content in the patients' day. However, further research is needed into how different staff conceptualisations of good care influence the actual care provided.

In this study, many of the descriptions of sharing place but not moment and sharing neither place nor moment could not be immediately related to either staff shortage or high workload. Rather, this seemed to emanate from a focus on routine work and tasks. It seemed that when morning routines were completed and time hit nine, it was time for staff coffee break and most every staff member left the unit. However, there is compelling evidence in the literature to conclude that less workload and high staffing levels are associated with high quality care, often measured as low prevalence for example of urinary tract infections, deaths, pressure ulcers and other adverse outcomes (Schnelle *et al.* 2004). Nevertheless, we think, a low prevalence of adverse outcomes does not encapsulate all aspects of high quality dementia care and higher staffing levels may not necessarily translate to more time spent interacting with patients/residents. If high quality dementia care is conceptualised as involving person-centred care with meaningful activities and social participation, only measuring the prevalence of adverse outcomes is not sufficient to decide if high quality dementia care has been established. Cohen-Mansfield and Bester (2006) argued that high quality, person-centred dementia care involves a shift in priorities by staff to prioritising interaction and resident well-being ahead of tasks and routines and thus increased staffing levels may not immediately translate into better care.

The concept of presence is often described as pivotal for caring in nursing. The concept was first introduced in nursing theory by Paterson and Zderad (1978), who described presence as a mode of being available for, receptive and open to another person in a reciprocal fashion. Since the 1980s a significant amount of literature related to nursing presence has been generated where several authors place presence as a caring trait of nursing and as a necessity for developing a caring relationship and environment (Benner 1984, Nelms 1996, Doona *et al.* 1999, Covington 2003).

In relation to methodology, the observers were nurse researchers coming in from outside and thus not part of the ward staff. It is likely that observer presence at the ward might have influenced behaviours and interactions, at least initially. However, from a perspective of researcher role in qualitative studies as being co-constructors of meaning (Patton 2002), we argue that observer presence was a necessity for illuminating the research question in focus. In addition, we applied an embodied research approach (Edvardsson & Street 2007), which meant that observers used their own sensory experiences as part of the data collection. These were used in a reflexive process of interplay between sensate experiences and analytical logic to generate preliminary interpretations influencing further collection of observational data.

Limitations of the study

One limitation of the study is that the results are based on observations in one clinical setting, which means that the sample is small and context dependent. This needs to be considered when interpreting the results and conclusions. As a consequence, we do not know if the phenomenon under study would differ between participants and settings. These are two important issues worthy of additional study as the findings would benefit from further exploration in additional settings and participants. Do our data meet the commonly posed demand in grounded theory studies for saturation? We are confident that data is sufficient to merit our arguments, but as stated above, further analyses of additional data would enable further understandings of this complex phenomenon.

Conclusion

Staff presence and absence emerged as the core concept influencing the psychosocial climate and the well-being of people in dementia in a psycho-geriatric setting.

Relevance to clinical practice

To provide quality care to people with dementia, staff need to be aware of the significant influence of their presence or absence on the psychosocial climate and patient well-being. An awareness of this intimate connection calls for an ethical responsibility to question routines that entail staff absence and/or nursing tasks with minimum of staff-patient interaction, and also to make explicit that good care for people with dementia means prioritising issues of 'being with' inasmuch

as 'doing for' in different settings. The findings have implications for management as well as for staff.

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Contributions

Study design: DE, P-OS, BR; data collection and analysis: DE, P-OS, BR and manuscript preparation: DE, P-OS, BR.

Conflict of interest

The authors have no conflict of interest to claim.

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