



Understanding functional ability: Perspectives of nurses and older people living in long-term care



Vilhelmiina Lehto^{a,b,*}, Outi Jolanki^{c,a,b}, Jaakko Valvanne^{d,b,e,f}, Lauri Seinelä^{d,b,g,h}, Marja Jylhä^{a,b}

^a Faculty of Social Sciences, University of Tampere, Finland

^b Gerontology Research Center, University of Tampere, University of Jyväskylä, Finland

^c Department of Social Sciences and Philosophy, University of Jyväskylä, Finland

^d Faculty of Medicine and Life Sciences, University of Tampere, Finland

^e Geriatric Unit, Tampere University Hospital, Finland

^f Social Services and Outpatient Care, Welfare Services, Tampere, Finland

^g Purchaser for the Promotion for senior citizens welfare, Tampere, Finland

^h Pirkanmaan erikoislääkäripalvelu Oy, Tampere, Finland

ARTICLE INFO

Keywords:

Functional ability
functioning
long-term care
positioning theory
discourse analysis

ABSTRACT

The functional ability of older people has come to play a significant role in their care. Policies and public debate promote active aging and the need to maintain functioning in old age, including among older people living in long-term care. This study explores the meanings given to functional ability in the interview talk of long-term care nurses (n = 24) and older people living in long-term care (n = 16). The study is based on discourse analysis and positioning theory.

In this study, accounts of functioning differed between nurses and older residents. For the nurses, functional ability was about the basic functions of everyday life, and they often used formal and theoretical language, whereas for older long-term care residents, functional ability was a more versatile concept. Being active was promoted, particularly in the nurses' talk but also sometimes in residents' talk, thereby reflecting the public discourse about functioning. In their talk, the nurses positioned themselves in relation to functional ability as competent professionals and active caregivers. In residents' talk, we found three positions: an active individual taking care of him or herself, a recipient of help, and a burden to nurses. To move in a direction that promotes activity and rehabilitative care, a better understanding of older people's individual needs and their own views of functional ability is needed.

Introduction

Functional ability and long-term care

In this study, we analyze the meanings of functional ability¹ in the interview talk of long-term care (LTC) nurses and older people living in LTC. Functional ability is broadly understood here as an individual's capacity to carry out the activities that he or she needs or wishes to carry out in a given environment. Functioning has become an important part of elderly care, not least because of the paradigm of active aging that highlights functioning and independence (Katz, 2000; World Health Organization, 2002a). In public discourse, those who remain active in their later years are seen in a positive light (Weicht, 2013). Active aging has been promoted worldwide; however, consensus has

not been reached on its meaning, and it has been criticized for excluding the frail and dependent (Boudiny, 2013; Walker, 2002). Increasing age is associated with the risk of decreased functioning. LTC residents, who are often frail elders with progressive diseases, could be regarded as a group that is not achieving the ideal of active aging. However, geriatric rehabilitation programs and general aging policies aim to change the care culture in LTC by shifting it toward the promotion of activity (see Routasalo et al., 2004).

Measuring functional ability plays an important role in aging research, and a range of instruments have been used to assess older people's functioning (Guralnik & Lacroix, 1992). Activities of Daily Living (ADL) (Katz et al., 1963) is a traditional method to assess older people's functional ability and is widely used in LTC (den Ouden et al., 2015; Grönstedt et al., 2013; Littbrand et al., 2009; Phillips et al.,

* Corresponding author at: Faculty of Social Sciences, 33014, University of Tampere, Tampere, Finland.

E-mail address: Lehto.L.Vilhelmiina@student.uta.fi (V. Lehto).

¹ In Finnish, the word *toimintakyky*, which refers to the extent to which an individual is able to carry out different activities, can be translated as “functioning” or “functional ability.” In the text, we use both, depending on the context.

2007). The Resident Assessment Instrument (RAI) is commonly used worldwide, including in Finland (National Institute of Health and Welfare, 2017), to assess LTC residents' functioning and the quality of their care (Kahanpää et al., 2016; Onder et al., 2012). In addition to these, physical performance measures (Grönstedt et al., 2013; Peri et al., 2008) are used, to mention but a few. In gerontology and geriatric nursing textbooks, functioning is often classified into physical, mental or cognitive, and social categories (Guralnik & Lacroix, 1992; Harrison, 2013; Heikkinen et al., 2013). Guralnik and Lacroix (1992) add sensory functioning to this list. Based on a biopsychosocial model, the International Classification of Functioning, Disability and Health offers language and concepts for the discussion of disabilities and functioning, describing functioning as a mixture of not only health conditions but also personal and contextual factors (World Health Organization, 2002b).

Long-term care in Finland

In Finland, the municipality is responsible for organizing elderly care services. These services can be provided by the municipality itself, together with other municipalities, or the municipality can buy the services from a private provider (Finlex, 1982; Finlex, 2012). Elderly LTC consists of nursing home care, LTC wards in health center hospitals or community hospitals, and assisted living with 24-hour assistance and care (Johansson, 2010). At the end of 2015, 0.4% of Finns aged over 75 lived on an LTC ward and 1.7% in a nursing home, whereas 7.1% lived in assisted living facilities (Sotkanet Indicator Bank, 2017). Recent research shows that the use of LTC increases with advancing age and in the last years of life (Forma et al., 2017). Nursing homes and LTC wards are regarded as institutional care. In Finland, as in many other countries, there has been a shift toward the reduction of these institutions (Anttonen & Karsio, 2016; Ministry of Social Affairs and Health, 2013) in favor of so-called homelike facilities, such as assisted living with 24/7 care. In both institutional care and assisted living with 24-hour care, the majority of employees are practical nurses. There are also other employees, such as registered nurses or physical therapists. A physician is available for consultation mostly by phone and may visit the facility a few times a month. On LTC hospital wards, the physician may be present daily.

Policy debate around elderly services in Finland emphasizes the care providers' responsibility to support the functioning of their residents. Function-focused care and the promotion of older people's functioning are required by national quality recommendations and by law (Finlex, 2012; Ministry of Social Affairs and Health, 2013). In Finland, disability is the main criterion to qualify for a place in LTC. Moreover, policies such as "aging in place" are based on the expectation that care services support the idea of older people living in their own homes for as long as possible (Ministry of Social Affairs and Health, 2013). This means that they usually have remarkable disabilities by the time they move into an LTC facility. Functional ability is, thus, an important issue among those living in LTC. In addition to promoting functioning, a major principle in present-day LTC is "person-centered care," which emphasizes the self-determination of older people and partnership between the individual and the caregiver rather than the treatment of older people as objects of care (McCormack, 2003). In Finland, person-centered care is expected by the law (Finlex, 2012).

The aim of this study

This study analyzes the interview talk of nurses and older people living in LTC regarding functional ability in the context of LTC. To our knowledge, no previous study has investigated this theme. The ways in which people talk can be seen as not only reflecting but also constructing the reality (Burr, 1996). We have approached functional ability as a discursive phenomenon. The ways in which LTC nurses and residents talked about functioning were examined by drawing on

discourse analysis and using the concept of positioning. Position analysis has been utilized in elderly care, for instance, when studying client engagement and the power relations between residents and staff (Petriwskyj et al., 2014). Taking particular positions and using certain discourses can have both positive and negative consequences and can even contribute to tolerance for the mistreatment of older people in care homes (Sabat, 2003; Stevens et al., 2013). Therefore, discourses in care facilities have significance for good care and are worth looking at more closely. An analysis of the interview talk of LTC nurses and residents can help us to understand the care culture in these facilities. Although originating from research interviews instead of from an authentic care situation, we think that the ways of talking in interviews reflect social and, for nurses, professional norms, as well as public discourses concerning elderly care and functioning (Allen and Wiles, 2013; Harré et al., 2009).

Material and methods

Interviews

We conducted semi-structured one-on-one interviews with LTC nurses and older LTC residents. The interviews took place in eight different LTC facilities in two cities in southern Finland with populations between 215,000 and 230,000. After acquiring approval for our study from the cities' ethical committees, we requested a list of the care facilities where the cities offered LTC for older people. We included all the facilities using the RAI (National Institute of Health and Welfare, 2017). We excluded two facilities where the first author had previously worked. From the included facilities, we chose two in each city that provided institutional care and two that provided assisted living with 24/7 care. After we contacted these facilities, two assisted living facilities declined to participate because they could not find eligible participants for this study. Consequently, two more assisted living facilities were chosen. In the other city, there was only one hospital providing institutional care that was eligible for this study. Two different wards in this hospital were contacted. One of these wards declined to participate, so the hospital was given an opportunity to choose another ward to participate (Table 1).

The ethical committee of the local hospital district and the manager of each facility approved our research plan. The first author contacted the facilities by e-mail or by phone, after which written information about the study was sent to the manager of each facility. The care facilities were asked to choose three nurses and two residents to participate in the study. Eligible residents had to have no more than a minor memory impairment to ensure that they could give informed consent. This was confirmed with an adequate memory test score (Mini Mental Status Examination MMSE > 18) or Cognitive Performance Scale score (CPS ≤ 2). The interviews in the care facilities were carried out by the first author. The interviewees were told that the interviewer was also a registered nurse.

There were 40 one-on-one interviews altogether. The nurses (n = 24) interviewed for this study had worked as nurses for between

Table 1
Participating facilities and number of nurses and residents interviewed.

City	Care facilities	Public/private	Nurses	Residents
#1	Nursing home	Public	n = 3	n = 2
	Nursing home	Public	n = 3	n = 2
	Assisted living facility	Private	n = 3	n = 2
	Assisted living facility	Private	n = 3	n = 2
#2	LTC hospital ward	Private	n = 3	n = 2
	LTC hospital ward	Private	n = 3	n = 2
	Assisted living facility	Private	n = 3	n = 2
	Assisted living facility	Private	n = 3	n = 2
Total	n = 8		n = 24	n = 16

Table 2
Nurses' positions in their interview talk about functional ability: Competent professional and active caregiver.

Group	Subject position	Discourse	Excerpts showing how functional ability is described
Nurses	Competent professional	Functioning as an abstract category Functional ability as independence Functional ability as part of daily life Functional ability as a target of nursing interventions	<i>So, it is that. Mental, physical, cognitive, this is the wholeness of the human being. Are you able to do anything yourself, or is everything done for you. It is that you cope in your daily functions. We always try to see and find those resources everyone has, and [to see] what one can do. And a little more from there like, then, with rehabilitative nursing, we try. One gets more, like, what one thinks one is capable of.</i>
	Active caregiver	Functional ability as tangible daily activities	<i>Is one able to go to the toilet and to change one's clothes. Is one able to bathe, take care of hygiene, brush one's teeth. Does one remember to come to eat or how to eat.</i>

one and 40 years. They had been working between one and a half months and 20 years at their current care facility. Nearly all ($n = 23$) the nurses were female. Nineteen of them were practical nurses and five were registered nurses. The residents ($n = 16$) participating in this study had lived in their current care facility for between one month and seven years. Two of them could not give an answer about how long they had lived there. More than half ($n = 11$) of the interviewed residents were female.

The interviews were conducted during autumn 2016. The interview guide was formulated jointly by authors 1, 3, 4, and 5 utilizing the expertise and experience of the group. The themes of the interviews—functioning and rehabilitation—were decided beforehand, but the interviewees were given the opportunity to elaborate on the themes. Lasting between 16 and 58 min, the interviews were audio-recorded with the consent of the interviewees and transcribed verbatim. The analysis of this study concentrated on the parts of the interviews in which the participants were asked about the functional ability of older people living in LTC. The nurses were asked to describe the meaning of “functional ability”—that is, what they were talking about when they discussed functional ability in the LTC context. The residents were asked how they would evaluate and describe their own functional abilities.

Analysis

This study draws on discourse analysis based on social constructionism as an approach to understanding the meanings constructed in participants' talk (Burr, 1996). Discourse analysis focuses on how language is used and the functions that the language has (Burr, 1996; Potter & Wetherell, 1987), as opposed to merely reporting what is said. The first stage of the analysis was to read and reread all the transcribed interviews several times and to get to know the data. During this stage, notes were written in the transcripts, and preliminary coding was done. The aim was to find recurrent patterns of talk—that is, in what way the participants defined functional abilities. These patterns of talk are referred to as discourses. Drawing from positioning theory (Allen & Wiles, 2013; Harré & Lagenhove, 1999; Harré et al., 2009), we were interested in how participants positioned themselves in relation to functioning. For this self-positioning, we use the term subject position. The next stage of the analysis concentrated on how the patterns of talk—the discourses—constructed different subject positions. With each discourse, we examined what kind of position it was constructing for the speaker—that is, what kind of function the discourse had. We noticed that in some cases, several discourses represented the same subject position. Positions can change, and repositioning can even occur during a single speech act (Langenhove & Harré, 1999, pp. 17–18), resulting in the overlapping and intertwining of the positions. In the analysis, one interview excerpt could be categorized into several discourses.

During the process, authors 1, 2, 3, and 5 read all the data and made their individual observations based on the research aim. All the authors then discussed these findings and the preliminary analyses by the first author to reach a consensus about the identification of the discourses and the positions they represented. The first author then conducted the

final analysis after several, frequent consultations with the other authors.

Results

In the data, we found different subject positions for both the studied groups. As is typical, the subject positions were often overlapping rather than separate. In the excerpts, all the names are pseudonyms, and VL refers to the interviewer.

The nurse as a competent professional and active caregiver

We looked at nurses' talk in the interviews using the discourse analysis approach to see what kind of subject positions the nurses constructed in their discourses on functional ability. We could distinguish two different subject positions: competent professional and active caregiver (Table 2). The difference between these two is that when the nurses positioned themselves as competent professionals, they used theoretical, formal, and abstract language. When they positioned themselves as active caregivers, they talked about the concrete daily activities of the residents that affected their work as nurses. In several cases, however, these positions intertwined.

Functional ability had several meanings. In the next excerpt, Laura, a registered nurse working in an assisted living facility, replies to the question about functional ability:

VL: *Okay. Well, could you tell me in your own words what it means when we're talking about the functional ability of older people living here in this kind of care home?*

Laura: *What functional ability?*

VL: *Functional ability. Like when we're talking about functional ability—*

Laura: *Err, in my own words.*

VL: *What does it mean?*

Laura: *Well, to me, when I think of functional ability, I think of this kind of physical and psychological well-being. What a resident can do by himself and in what he needs help.*

At first, Laura is somewhat hesitant to answer the interviewer's question. She asks, “What functional ability?” This could be interpreted in different ways: Either Laura has not quite heard the question, or she presumes that there are different domains of functional ability and is asking which domains she should talk about. The interviewer tries to clarify that, in this case, she wants Laura to talk about functional ability as a whole. Laura then defines functional ability in a very objectified way, dividing it into two domains. She uses abstract concepts: “physical” and “psychological” well-being. Mentioning different domains was typical when talking about functional ability as an abstract category, and the domains that different nurses mentioned were largely the same. This talk is not a part of everyday language; rather, it is theoretical and likely draws on a formal description of functioning that was learned during their studies, as well as textbooks and policy papers.

Laura then describes functional ability as an activity that a “resident can do by himself” or, conversely, as “in what he needs help.” She constructs functional ability as independence when she states that it is

an activity that a “resident can do by himself.” The dichotomization of residents as either independent or bedridden was repeated in the nurses' talk. Functional ability was described with regard to how independent one was and what one was able to do without help.

In the nurses' interviews, functional ability was linked to nursing interventions. These were, for instance, the evaluation of functional ability, rehabilitation or function-focused care, and individual care. By describing these, the participants were efficiently constructing themselves as both competent and good nurses. In the next excerpt, Liisa, a registered nurse who works on an LTC ward, tells the interviewer how she understands functional ability. The interviewer refers to this facility as a nursing home. RAI is the instrument that the nurses use to evaluate the residents' functioning.

VL: Okay. Well. How would you describe, in your own words, what it means when we're talking about the functional ability of a resident living in this kind of nursing home?

Liisa: Well. Usually, when we're doing care plans, as we still do for everyone, every six months, we check it after the RAI, after we fill the RAI instrument, we always update it. Quite often, there will be that sentence that we try to maintain the functioning that is still left. Like. No, there isn't going to be that much of something, like, else.

VL: Yeah, right.

Liisa: Like, we aim for it to not get to a worse condition.

Here, Liisa begins her account by referring to the written care plans that nurses make for every resident. She states that they are updated every six months after the nurses fill out the RAI measurement instrument. She also explains that they use “that sentence”—a specific sentence, in which they mention the possibility of maintaining residents' functioning. She also talks about herself as a part of nurses as a group by saying that “we” update it and “we” try to maintain the functioning. This kind of talk positions nurses as actors in maintaining residents' functioning and residents as objects of nurses' actions. She even strengthens her statement by saying that they “always” update the care plans. We categorized talk about making and updating care plans, measuring functioning using the RAI, and supporting functioning as a discourse of functional ability as a target of the nurses' intervention. This discourse was used to construct the position of a competent professional, demonstrating knowledge about nurses' obligations and tasks in terms of the care system.

We interpreted discourses about functional ability as an abstract category, functional ability as independence, and functional ability as a target of nursing interventions as reflecting the subject position of a competent professional. Discourses in this position included talk in which nurses made functional ability appear as a broad concept that is quite distant from the daily life of the care facility. Several of the nurses used the same phrases: “how independent one is” or “physical and psychological well-being.” By positioning themselves as competent professionals, the nurses simultaneously depersonalized the residents as a group of frail people in need of help.

When positioning themselves as competent professionals, the nurses described functional ability as daily life in the care facility. In response to the question about what functional ability is, a common phrase was simply “daily activities” without the inclusion of any details. Contrary to this rather abstract vocabulary of the subject position of the competent professional, the position of the active caregiver was characterized by more concrete and detailed descriptions of physical activities, such as eating, moving, getting dressed, and taking care of one's own hygiene. In some cases, participation in social activities was also mentioned. In the following excerpt, Kirsti, a practical nurse who has worked on this LTC ward for almost 30 years, describes functional ability as different tasks in daily life. What is interesting is that in her talk, the positions of the competent professional and active caregiver overlap and exist at the same time.

VL: Okay. Well. Mm, how would you describe, in your own words, what it means when we're talking about the functional ability of old people living in a nursing home like this?

Kirsti: [Sighs] Mm. Well, it is, after all, coping. With all the tasks of the day: eating, dressing, washing. All the daily chores. Totally. And, indeed, moving, and eating, and. Mm participation and. Everything that belongs to life how you yourself, how, how we, we who still have everything left. Yeah and the social side. Like how. It is exactly the same in institutions, in the nursing home, like nevertheless, that. Sure, it is like that. They wouldn't be in an institution if they wouldn't have in some area-. These days, you almost should, have in every area, like, well, a need of help or a need of assistance or a need of guidance.

Here, Kirsti is stating that functional ability in a nursing home is “coping with all the tasks of the day.” She connects functional ability to everything that happens in a nursing home during a day: “all the functions,” “all the daily chores,” and “everything that belongs to life.” These statements paint a big picture of functional ability as something broad, inclusive, and difficult to describe because it is “everything.”

Describing functional ability was not an easy task for the nurses. In several cases, the nurses' talk was very hesitant. This can be seen in the previous excerpt with Kirsti. She uses several filler words when trying to explain her understanding of functioning. Several of the nurses underlined that what they said were only their own thoughts and opinions and not necessarily the opinions of nurses as a group. This was interesting, because although they did not present themselves as part of a group, their views and the phrases they used were very similar.

Kirsti is constructing the subject position of the active caregiver when she specifies the different daily activities: eating, dressing, washing, and participation. At the end of her account, she states that they would not be in an institution if they were not in need of help. Hence, she is justifying the residents' need for their help. Even when she says that “you almost should have [the need for help] in every area,” she is stating that the residents do have a need for help if they are living in a nursing home. This could also be regarded as a discourse that constructs the other subject position: a competent professional. The competent professional knows that residents' functioning is evaluated before they enter a care home and that a decline in functioning is a prerequisite for admission. When she positions residents as people needing nurses' help, she simultaneously positions nurses as active caregivers and justifies both the residents' place in a nursing home and the nurses' role as their caregivers.

LTC residents as active individuals and recipients of help

Older LTC residents' talk in interviews about functional ability was not as abstract or formal as nurses' talk. The concrete aspects of functional ability were described not only in terms of what residents could do by themselves but also which tasks they needed help with. The residents described functional ability as not only daily chores, such as eating or dressing, but also as activities that were not necessarily basic daily tasks but were, nevertheless, important to them.

Functional ability was connected to resilience. The residents used different aids and managed their lives so that they were able to do the activities they were currently able to do, even if these were done with difficulty. The residents talked about the changes in their functional abilities. These changes were often due to different diseases or impairments. Change could also be described through experiences in previous health-care environments. The residents compared their functional abilities with those of other people. Although many assessed their own functional abilities favorably compared with those of other residents, some of them stated that their conditions were no longer good. Functional ability was linked to their own personal life course: what had been, what was, and what seemed to be the future or feared future.

We could find three different but intertwining subject positions in residents' interview talk (Table 3): an active individual taking care of him or herself, a recipient of help, and a burden to the nurses.

In this next excerpt, the interviewer is asking Aino, a woman who lives in an assisted living facility, how she would evaluate her

Table 3

LTC residents' subject positions in their talk in interviews about their own functional abilities: active individual taking care of him or herself, recipient of help, and burden to nurses.

Group	Subject position	Discourse	Excerpts showing how functional ability is described
LTC residents	Active individual taking care of him or herself	Independence Managing to maintain good functional ability Functional ability as coping	<i>It [functional ability] is pretty good. I do know how to dress myself and (VL: Yes). And I cleaned up, too, when I was at home by myself-. By myself everything and washed the laundry. Well, I wouldn't, wouldn't say it [functional ability] is poor yet. It is poor when one stays-. When in everything one needs help. But I don't need help yet with everything. I have poor vision, that I must say: that I have poor vision. That restricts me. But as long as I see with my glasses and then with the magnifying glass, it works. Well, the whole functioning of my left side has been lost (VL: Yes). In my hand and foot. (VL: That's right). The result of an infarct. These hands are-. They have done a lot of work before that I'm not able [to do] anymore.</i>
	Help recipient	Poor functional ability as physical illness or impairment Present functional ability as compared with that in the past	<i>I do try here, too; when there's only a few nurses, I try to help. I dress myself on my own, hands and all. These kind of things. Nurses don't help almost at all.</i>
	Burden to nurses	Functional ability as a means to help nurses' work Functional ability as not needing help from nurses	

functional ability. The interviewer has just asked Aino how she would evaluate her health status—whether it is very good, quite good, quite bad, or bad—to which Aino has replied that her health is quite bad.

VL: *Quite bad. Well, how would you evaluate your functional ability using this same scale?*

Aino: *Well, I can still do some things and-, and I have done, too.*

VL: *Yeah.*

Aino: *But, well. This isn't easy. This, your own will, is always tested.*

VL: *Yes.*

Aino: *We have this visit to the sauna, too. When you don't have enough strength to wash yourself. And there are many people at the same time, and you can't ask, only one nurse is washing. So it is then, I prefer to be, I try myself rather than ask.*

VL: *Yes. Well, how would you evaluate your functional ability using this scale? Is it very good, quite good, quite bad, or bad?*

Aino: *Well, if you put a seven there, what would it be?*

VL: *Well, it is a little like on the better side, so would it be quite good then?*

Aino: *Yes. It would. I can't say. It's not that good anymore.*

VL: *Mm.*

Aino: *I do try here, too, when there's only a few nurses. I try to help, but the helping, on the other hand, backfires because I am now one year to 90.*

Aino presents herself as an active individual who takes care of herself. She says that she is able to function—to “do some things.” She grades her functional ability as a seven; this is most likely based on the Finnish school grading system, which ranges from four to 10. She uses temporal framing by saying that she “still” has the ability to function in some way. The participants often used this same wording about “still” being capable of doing things. This discourse, in which residents stated that they had managed to maintain good functional ability, constructed the subject position of active individuals taking care of themselves. Managing to stay in good condition—sometimes in contrast with other residents with poor functional abilities—indicated that they had been, and still were, active in some sense.

Aino describes a situation in which the residents go to the sauna and there is only one nurse to help them. She then, once again, puts herself in the position of someone who is taking care of herself by saying that she does not want to ask for help and, therefore, tries to cope on her own. By doing this, she tries to help the nurses, too. This, she says, “backfires,” and by stating her age, she justifies herself as someone who actually needs help. The residents often described their ability to do several things on their own so that the nurses, who have so much work to do, do not have to help them or have to help them very little. In this discourse, they positioned themselves as being a burden to the nurses, at least potentially. In her talk, Aino is even more straightforward, describing that she feels that there are only a few nurses available to help and that she, therefore, tries to ask for as little help as

possible—for example, when she is at the sauna.

In this next excerpt, Hilda, a woman living in a nursing home, describes her functional ability in response to the interviewer's question:

VL: *Yeah. Well, how would you evaluate your functional ability? Is it very good, quite good, quite bad, or bad?*

Hilda: *Well, otherwise, I have, but when I have to walk with that wheeled walker, it is that kind of-, that it's, my support.*

VL: *Yes.*

Hilda: *But, otherwise I am. I walk there, and then I move a lot.*

VL: *Yeah. Well, on this scale, how would you evaluate your functional ability? Is it very good, quite good, quite bad, or bad?*

Hilda: *Well, I now say this. That kind of, that this is-. This is, in my opinion, is when I compare to those others. I move here more and, and like that. I am in those-. I participate in all of those that-. I think this is good.*

VL: *Quite good?*

Hilda: *Yes.*

VL: *Yeah. Well, how would you describe your functional ability?*

Hilda: *I can't describe it now, but here is everything ready for you: food, clothes, they are washed, and this kind of thing, that these things are here ready. But I do get up every day by myself. And dress myself, and make my bed, and put my room in order, and then I go and look down there because the breakfast is there and I go there to eat. While others have to be looked for in their rooms and-.*

VL: *Yes.*

Hilda: *And then that, I think I am still in pretty good condition.*

Hilda's first account of functional ability is related to walking. She is clearly connecting functional ability to moving from one place to another. The tasks described in detail in the residents' talk were largely identical to those in the nurses' talk: moving, dressing, and eating. However, the residents also mentioned activities that were missing from the nurses' talk: writing, seeing, hearing, drawing, and watching television. The ability to draw is an example of an activity that may have little relevance in the context of the nurses' work and was, therefore, not included in their accounts; however, for an older person, it may be the most important thing that he or she can still do.

When Hilda says that she moves a lot in the care home, and she describes how she gets up by herself, makes her bed, and goes downstairs to eat, she is using the independence discourse to construct herself as an active individual who takes care of herself. Within this discourse, residents demonstrated their ability to do things.

The wheeled walker can be seen as an important aid to Hilda. She links functional ability to methods of coping when she describes how she can move and walk but only when she has her walker with her. Different aids were important to the residents. For instance, walkers, wheelchairs, and magnifying glasses were some of the devices that were mentioned by the residents in their talk about their functional abilities. They said that these were helpful aids and that they might not cope

without them. They also had their own methods of doing things—for instance, when getting out of bed—which was another way of coping.

What strengthens Hilda's position as an active individual is her use of the discourse of managing to maintain good functional ability. In her talk, Hilda compares herself with other residents who “have to be looked for in their rooms.” She compares herself to these “others” and says that she is, in fact, “still in pretty good condition.”

The next excerpt is from an interview with Ester, a woman who, at the time of interview, had been living at the nursing home for nine months.

VL: Yeah. Well, what if you evaluated your own functional ability? Is it very good, quite good, quite bad, or bad?

Ester: Well, it probably isn't good because here-. The other side is paralyzed and-. I can't use it at all.

VL: Yes.

Ester: Yes. So, it isn't bad, but it isn't good.

VL: That, no-. Is it quite good or quite bad?

Ester: Quite bad. Because you can't move at all now like this. Only with this wheelchair.

VL: Yes.

Ester: Yes.

VL: Well, you said that your other side is paralyzed, but how-, is there-, how would you define your functional ability? What is it like?

Ester: Well, in some sense, it is good, too, because I dress myself and I dress my arms, and all. These kinds of things that nurses don't help with almost at all.

Ester constructs herself as a recipient of help by stating that her functional ability is not good because one side of her body is paralyzed. She states that her functional ability “probably isn't good because” of her disability. In this way, Ester is justifying her need for help: She cannot say that her functional ability is good. In this kind of talk, the physical body limited the residents' independence and justified their need for help. When the interviewer returns to this subject by asking Ester to assess her functional ability, she states that in “some sense, it is good, too.” She then shifts to the subject position of an active person taking care of herself by stating that she is able to dress herself. Ester strengthens her statement by saying that the nurses do not actually need to help her that much. In fact, in her talk, Ester is negotiating her position; her functioning is “probably not good” because she cannot move and is, therefore, in need for help. Conversely, she uses a wheelchair to move around, and with this statement, she links functional ability to methods of coping.

Discussion

In this study, we were interested in how the functional ability of older people living in LTC is understood by the nurses and by the older LTC residents themselves. The rationale for this study is based on our conviction that the ways in which functioning is understood inform the ways in which it is taken into account in the practices in LTC facilities and the measures that are taken to promote residents' functioning. We analyzed the constructions of functional ability in LTC nurses' and residents' interview talk, and we deepened this understanding by looking at these speech acts through the concept of positioning.

In their talk in interviews, the nurses positioned themselves as competent professionals on the one hand and as active caregivers on the other. These positions differed in regard to how abstract and formal the talk was and how closely related it was to the nurses' everyday work chores. In the nurses' talk, functional ability commonly took shape either as a formal, standardized indicator or an abstract combination of physical, social, and psychological domains. Alternatively, it was described using phrases such as “everyday activities,” “how independent one is,” or “physical and psychological well-being.” Their way of speaking and choice of words seemed to be heavily influenced by official care policies and textbooks (Ebersole & Touhy, 2006; Finlex, 2012; Guralnik & Lacroix, 1992; Heikkinen et al., 2013; Katz, 2000;

McCormack, 2003; Ministry of Social Affairs and Health, 2013; Wallace, 2008). Our interpretation is that by using these discourses, the nurses presented themselves as competent professionals who were knowledgeable of the policy and practice guidelines in their field. The standard, rather abstract vocabulary that was used also suggests the political importance and sensitivity of the themes involved; it is important to be able to talk about functioning in the correct way.

In the nurses' talk, a powerful way to construct oneself as a competent professional was to refer to formal standardized assessments of functioning, such as the RAI. This kind of talk reflects the tradition of measuring functional ability in terms of activities of daily living (den Ouden et al., 2015; Grönstedt et al., 2013; Littbrand et al., 2009; Phillips et al., 2007) and the major role of the evaluation of functioning in LTC. It appears that methods that are meant for evaluation, such as the RAI, have an intrinsic value in nursing care and care culture. It remains unclear to what extent the use of these routine assessments in real life serve as a basis for the promotion of functioning, but our findings imply that the ways in which functioning is operationalized in these measurement indicators largely influence the ways in which nurses understand the very notion of functional ability.

Contrary to the position of competent professional, when nurses positioned themselves as active caregivers, they talked about concrete activities. In this discourse, functional ability was described as tasks of daily living for which inability would require nurses' actions. Here, functional ability was about the basic functions of everyday life, such as eating, dressing, moving, and taking care of hygiene. The same activities were also mentioned in the residents' talk, but to them, functioning was a more versatile concept. The nurses also talked about functional ability as something that defined residents as either independent or in need of help. However, to the residents, it was not a straightforward dichotomy between being dependent or independent; rather, it was about different ways of coping with functional problems. One of the key findings of the study was that the residents compared their functional ability with what it had been earlier or what it might be in the future, but the time dimension was missing from the nurses' talk.

In the residents' talk in interviews, we found three subject positions: active individual taking care of him or herself, recipient of help, and burden to nurses. These positions differed in their relationship with functional ability. To an active individual with reduced functional abilities, functional ability represented the effort to cope with health problems. The residents also related functional ability to the need for help, and similarly to nurses' talk, in residents' talk, activity and independence were positive aims to be pursued. However, apart from basic daily activities, such as eating and moving, the residents mentioned activities beyond daily chores. These actions, which the nurses did not mention at all, included writing, drawing, and watching television. Sometimes referred to as “anti-activities” (Katz, 2000), these are often missing from public discourse about functional ability. According to the findings of this study, older people opine that they play a role in their functional ability. The World Health Organization (2002b) highlights the contextual and personal factors related to functioning. Indeed, the residents' perceptions were usually very personal and were typically based on their previous experiences and lives. They also talked about functional ability as a factor that one should and could have influence on or, at least, do one's best not to worsen. Similar discourses on activity and independence have been found in nonagenarians' talk about health and functioning (Jolanki, 2004; Jolanki, 2009).

As in nurses' talk, in the residents' talk, activity and independence were positive aims to pursue. An interesting perspective of the residents regarding the extent of their own activity was provided by the subject position we called “burden to nurses.” Here, the residents emphasized the scarcity of nurses, and they, therefore, tried to ease nurses' work by being as independent as possible. In this position, the traditional roles of caregiver and care receiver were reversed; it was now up to the residents to lessen the nurses' burden.

The findings of this study show that there are differences in how

LTC nurses and residents understand the functional abilities of older LTC residents. The concrete actions connected to functional ability were mostly the same between the studied groups: eating, dressing, moving, and taking care of hygiene. In addition, the nurses described functional ability in terms of how independent residents were or how they managed their daily chores or daily lives in general. The study showed that nurses understand functional ability in terms of standardized measures, while residents understand it in broader and more contextual terms. The nurses understood functional ability as being more like a mechanical performance, while to residents, it was a mundane part of their life course. In particular, the nurses' talk reflected current policies and debates around elderly services, which strongly emphasize the promotion of functioning and activity in later years of life (Finlex, 2012; Katz, 2000; McCormack, 2003; Ministry of Social Affairs and Health, 2013; Weicht, 2013; World Health Organization, 2002a). Indeed, being active in later years has been regarded positively, and in discourses and policies concerning old age, the polarization between positive activity and negative passivity is evident (Katz, 2000; Weicht, 2013). However, the residents' talk about promoting activity and the importance of independence despite age and illness also highlighted the main ideas of current old age policies.

It is no surprise that participants' talk in interviews reflects the current public debate about functioning. Self-positioning always invokes broader social norms and public discourse (Allen and Wiles, 2013). Personal discourse should be studied within its cultural context and normative system, which indicate certain cultural duties (Harré et al., 2009, pp. 11, 26). As one is always positioning others while positioning oneself (Langenhove & Harré, 1999, p. 22), the nurse's position as an active caregiver presumes that someone is the care receiver. Indeed, LTC residents positioned themselves as care recipients and objects of other people's actions (Jolanki, 2009). However, it is important to note that the residents did not position themselves as care recipients only but also as active individuals who were taking care of themselves. The residents thus resisted the position of solely passive care receiver.

The ways in which the nurses in particular understood and talked about the functioning of older people in LTC are not without consequences; they are not “only talk.” Discourses indeed have “constitutive force” (Davies & Harré, 2007), and it is important to ask how the discourses are translated into practices of elderly care. In our study, the nurses talked about functional ability as either an object of formal measurement or intervention or as basic activities of daily living that potentially require their help. We also found that there was some hesitation among the nurses when they were asked about their understanding of functional ability. They often ended up using the same general phrases that are found in official policy papers. This implies that there are not many discourses available for them to choose from. In this sense, we found the residents' talk richer and more contextual than the nurses'. Therefore, even if promoting and maintaining functional ability is a widely shared goal, in this study, the priorities of the nurses and the older people may differ. Alternative discourses highlighting the views of older LTC residents and the personal and contextual side of functional ability are needed.

In addition, the organizational culture is constructed through the discourses that are used in daily situations of care. For instance, if the nurses—even without being aware that they have such power—talk about older people as requiring their help and not having a say in their care, they are reflecting a reality in which older people are constantly seen as objects of care and evaluation. Recent research (Petriwskyj et al., 2014) has emphasized that the traditional power relations between nurses and patients—that is, the nurse as a caregiver and the resident or client as a care receiver—resist the development of client engagement in elderly care. The positions and discourses that adopt these traditional identities and roles also support these traditional power relations in elderly care. The formal discourse that we found among LTC nurses may strengthen the image of older LTC residents as

passive care receivers and lead older people feeling that they are a burden to the care staff. This is contrary to the aim of helping older people to stay active in their later years.

The data for this study were collected in Finnish LTC facilities. The semi-structured one-on-one interviews were conducted in eight different LTC facilities, both private and public, incorporating institutional settings and assisted living facilities. The notion of functional ability is rather universal, as is nursing care; both are the key interests of our study. Therefore, we believe that the findings of this study can offer insight into the understanding of functioning in other environments. Due to limited financial and time resources, the number of interviews is not very large but is not smaller than is usual in qualitative studies. The plan was to cover different types of care facilities and to obtain as wide a range of perspectives as possible. Even though it is impossible to know whether a larger sample could have led to more variance in the discourses, this sample showed repetition of the same themes, and in this sense, saturation was reached. Only residents with good cognitive status were interviewed; this excluded, for instance, persons suffering from advanced dementia. These exclusions had to be made to ensure the informed consent of the participants. In the nurses' interviews, the fact that the interviewer was introduced as a nurse may have influenced the interviewees to some extent. It may have encouraged the nurses to emphasize their professional identities and to speak to a colleague in a politically correct way. The data were received in on-one-one research interviews, which is a situation that differs from ordinary care situations. Nevertheless, the ways in which the interviewees talked reflect the patterns of understanding among the nurses and, therefore, influence the daily practice of the care facility.

The aim of LTC is to support and maintain residents' functional abilities and to help them live their lives as individuals according to their own preferences. This aim can be difficult to achieve if the understandings of functional ability differ significantly between nurses and residents. Instead of emphasizing the evaluation of functioning and formal care rituals, everyday care work should be guided by a practical understanding that coincides with the reality of functional ability. Ideally, long-term care should promote the activity and rehabilitative care of older people, taking into account their own preferences. To move in this direction, there is a need for better recognition of older people's individual needs and their own views of functional ability.

Declaration of interest statement

We have no conflict of interest to declare.

Acknowledgements

We would like to thank all the care facilities and their staff and residents who participated in this study. This research was funded by OLVI Foundation (grant number 201520420).

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