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ORIGINAL ARTICLE

Factors associated with perceptions of dignity and well-being among older people living in residential care facilities in Sweden. A national cross-sectional study

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Abstract

The care of older people living in residential care facilities (RCFs) should promote dignity and well-being, but research shows that these aspects are lacking in such facilities. To promote dignity and well-being, it is important to understand which associated factors to target. The aim of this study was to examine the associations between perceived dignity and well-being and factors related to the attitudes of staff, the care environment and individual issues among older people living in RCFs. A national retrospective cross-sectional study was conducted in all RCFs for older people within 290 municipalities in Sweden. All older people 65 years and older ($n = 71,696$) living in RCFs in 2018 were invited to respond to the survey. The response rate was 49%. The survey included the following areas: self-rated health, indoor-outdoor-mealtime environment, performance of care, attitudes of staff, safety, social activities, availability of staff and care in its entirety. Data were supplemented with additional data from two national databases regarding age, sex and diagnosed dementia. Descriptive statistics and ordinal logistic regression models were used to analyse the data. Respondents who had experienced disrespectful treatment, those who did not thrive in the indoor-outdoor-mealtime environment, those who rated their health as poor and those with dementia had higher odds of being dissatisfied with dignity and well-being. To promote dignity and well-being, there is a need to improve the prerequisites of staff regarding respectful attitudes and to improve the care environment. The person-centred practice framework can be used as a theoretical framework for improvements, as it targets the prerequisites of staff and the care environment. As dignity and well-being are central values in the care of older people worldwide, the results of this study can be generalised to other care settings for older people in countries outside of Sweden.

KEYWORDS
care environment, dignity, older people, person-centred care, person-centred practice framework, residential care facility, well-being

1 | INTRODUCTION

The average life expectancy is increasing worldwide (World Health Organization, 2017a) and International Sustainable Development Goal number three highlights the promotion of well-being for all ages (United Nations, 2015). Previous research regarding well-being shows that older people living in RCFs have described the importance of meaningful activities for experiencing well-being. For an activity to be meaningful, it is important that it agrees with individual interests and hobbies (Boelsma et al., 2014; Slettebø et al., 2017). Activities have also been described as providing opportunities to seek contact with other residents (Falk et al., 2013) and prevent loneliness (Paque et al., 2018). Nevertheless, the previous research reports a lack of meaningful activities in RCFs (Boelsma et al., 2014; Falk et al., 2013; Paque et al., 2018; Slettebø et al., 2017; The Swedish National Board of Health and Well-fare, 2017b, 2018b, 2019b). In addition to well-being, dignity is a central value in the care of older people (International Council of Nurses, 2012; World Health Organization, 2017b). Previous research regarding dignity shows that self-determination (Hall et al., 2014) and individualised care (Ostaszkiewicz et al., 2020) are described as important aspects for experiencing dignity. Older people living in RCFs have described that to experience self-determination and individualised care, it is important to have choices in one's daily life (Hall et al., 2014; Kane & de Vries, 2017; Ostaszkiewicz et al., 2020). Furthermore, being informed about one's care is important for being able to make choices (Boelsma et al., 2014). To experience self-determination and to experience individualised care, older people at RCFs have described the importance of having control in one's daily life (Hall et al., 2014; Kane & de Vries, 2017). This is due to having control over what time to receive care and how one receives that care (Tuominen et al., 2016). Despite the importance of self-determination, choice and control for experiencing dignity, the previous research shows that staff at RCFs may fall short of promoting this (Hall et al., 2014; Hasegawa & Ota, 2019; The Swedish National Board of Health and Well-fare, 2017b, 2018b, 2019b; Tuominen et al., 2016).

In Sweden, approximately 71,000 persons aged 65 years and older are living in an RCF (The Swedish National Board of Health & Well-fare, 2018a). Most of them have an extensive need for care and/or are diagnosed with dementia (The Swedish National Board of Health & Well-fare, 2012a, 2019a). RCFs are staffed by care assistants (CAs), nurse assistants (NAs) and registered nurses (RNs). RNs constitute approximately 10% of staff (Swedish municipalities & regions, 2020). Care at RCFs involves both health care and social care and is regulated by both the Health Care Act (Ministry of Health & Social Affairs, 2017) and the Social Services Act. The Social Services Act states that the care of older people should ensure that they live in dignity and with a sense of well-being. Living in dignity and with a sense of well-being is named the Swedish national fundamental values (Ministry of Health & Social Affairs, 2001). In the Swedish national fundamental values, the definition of dignity takes a point of departure from the Nordenfelt and Blennberger definitions; i.e., if a person is to live a dignified life, the dignifying aspects of *personal integrity*, *self-determination*, *participation* and *individualised care* have to be respected (Blennberger & Johansson, 2010; Nordenfelt, 2003). Well-being is defined, in the Swedish national fundamental values, with respect to the values of *safety* and *meaningfulness*. Furthermore, the values required for living in dignity are described as prerequisites for a sense of well-being (Ministry of Health and Social Affairs, 2008).

The care of older people should also be person-centred (The Swedish National Board of Health and Well-fare, 2017a; World Health Organization, 2016). The most common values of person-centred care (PCC) are dignity, self-determination, individualised care and meaningfulness (Kogan et al., 2016). To put PCC into practice, the person-centred practice (PCP) framework can be used. The framework contains the constructs of *prerequisites*, *care environment*, *person-centred processes* and *person-centred outcomes*. There is a relationship between the constructs in the framework. To achieve person-centred outcomes, the prerequisites of staff, including knowledge, skills and attitudes to provide care, must be considered. When the prerequisites are applied in care, they are influenced by the care environment, which is the context in which the care is provided. The prerequisites and the care environment influence

What is known about this topic?

- The care of older people should promote dignity and well-being, but previous research reports that older people living in residential care facilities perceive a lack of dignity and well-being, which indicates a need for improvement.
- Dignity and well-being are person-centred outcomes, according to the person-centred practice framework.
- To improve dignity and well-being, it is necessary to know what factors are associated with perceptions of dignity and well-being among older people living in residential care facilities.

What this paper adds

- According to the person-centred practice framework, significant associations were found between attitudes of staff, thriving in the indoor-outdoor-mealtime environment and perceptions of dignity and well-being.
- In addition to the constructs in the person-centred practice framework, significant associations were found between self-rated health, mobility and dementia and perceptions of dignity and well-being.
- The person-centred practice framework, which targets the attitudes of staff and the care environment, could be used when designing interventions to promote dignity and well-being; in addition, individual factors need to be considered.

person-centred care processes. Although there is a relationship between the constructs, the prerequisites and the care environment must be considered first to provide person-centred care processes to achieve person-centred outcomes (Centre for Person-centred Practice Research, 2021; McCormack & McCance, 2006). Dignity and well-being can be interpreted as person-centred outcomes, as, according to the PCP framework, a feeling of involvement in one's care and a feeling of well-being are described as person-centred outcomes (Centre for Person-centred Practice Research, 2021; McCormack & McCance, 2006).

Previous research indicates a need to improve care in RCFs with regard to dignity and well-being. To improve this area, there is a need for well-designed interventions and knowledge of what factors to target. According to the PCP framework, the prerequisites of staff and the care environment are important factors for achieving dignity and well-being. Building on the PCP framework, this study aims to examine the associations between (a) dignity and well-being (dependent variables), (b) attitudes of staff and (c) indoor-outdoor-mealtime environments (independent variables). Individual factors such as age, sex and health status are not considered in the PCP framework; however, in this study, we also take individual factors into consideration. As many older people living in RCFs have an extensive need for care due to morbidity and long-term disabilities and/or are diagnosed with dementia, we find it important to also consider individual factors. Our hypothesis is that residents' perceptions of satisfaction with dignity and well-being are associated with the attitudes of staff, the indoor-outdoor-mealtime environments and individual factors. We suggest that perceptions of (a) respectful attitudes of staff, (b) supportive indoor-outdoor-mealtime environments and (c) good health are associated with higher satisfaction regarding dignity and well-being.

2 | METHODS

2.1 | Design

This study adopted a retrospective cross-sectional study design using self-reported data from a national survey by the Swedish National Board of Health and Welfare (NBHW) in 2018 and data from two national databases. The methods used are reported with reference to the STROBE checklist for cross-sectional studies (von Elm et al., 2008).

2.2 | Setting and sample

All RCFs within the 290 municipalities in Sweden were included. All residents 65 years and older (n = 71,696) living in these RCFs were invited to respond to the survey. The NBHW was responsible for distributing the survey. The survey was sent by post to all residents between March and May 2018. It was also possible to answer the survey online. Two reminders were sent during this period. If the respondent was unable to respond, a proxy (relative, friend, trustee, or staff) was asked to respond instead. The proxies were instructed to respond to the survey in a way that reflected the residents´ perceptions (The Swedish National Board of Health & Well-fare, 2018a). Proxy answers were accepted in this study.

2.3 | Data collection

Data were collected by the national survey conducted by the Swedish NBHW in 2018. The national survey is distributed to all RCFs in Sweden every year, and the results aim to support quality improvements in care (The Swedish National Board of Health & Well-fare, 2012b). The survey includes 27 questions regarding the areas of self-rated health, indoor-outdoor-mealtime environment, performance of care, attitudes of staff, safety, social activities, availability of staff and care in its entirety (The Swedish National Board of Health and Well-fare, 2018c). When developing the survey, a reference group consisting of participants from the municipalities provided input regarding the relevance of the questions. The survey was then tested by a cognitive process where an interviewer, together with older people, performed the survey and it was further peer-reviewed by methodological expertise (The Swedish National Board of Health & Well-fare, 2012b). The survey has been used in previous research (Hammar et al., 2020).

2.3.1 | Measures of dependent variables

Dignity was measured using three survey questions regarding performance of care. The Swedish national fundamental values state that if residents are to perceive dignity, it is required that staff at RCFs pay respect to residents' personal integrity, self-determination, participation and that care is perceived as individualised (Ministry of Health and Social Affairs, 2008). Accordingly, survey questions with a focus on *personal integrity*, *self-determination*, *participation* and *individualised care* were identified to measure dignity. An overview of the dependent variable of dignity and how the questions in the survey are linked to the value of dignity in the Swedish national fundamental values is presented in Table 1.

Well-being was measured using two survey questions regarding safety and one survey question regarding social activities. The Swedish national fundamental values state that if residents are to perceive well-being, it is required that they feel both safe and meaningful. Accordingly, survey questions with a focus on *safety* and *meaningfulness* were identified to measure well-being. An overview of the dependent variable of well-being and how the questions in the survey are linked to the value of well-being in the Swedish national fundamental values is presented in Table 1.

TABLE 1 Overview of the dependent variables in all statistical models

Model	Question	Response alternative	Source	Link to The Swedish national fundamental values: Dignity and well-being
Model 1 Dignity	Do staff inform you beforehand about changes in your care?	Ordinal response treated as categorical variable. 1 = Always 2 = Most of the time 3 = Sometimes 4 = Seldom 5 = Never	NBHW survey	*Dignity*: Respect for personal integrity Participation Individualised care
Model 2 Dignity	Can you influence what time to get care?	Ordinal response treated as categorical variable. 1 = Always.....5 = Never	NBHW survey	*Dignity*: Respect for personal integrity Self-determination Participation Individualised care
Model 3 Dignity	Do staff consider your opinions and wishes regarding your care?	Ordinal response treated as categorical variable. 1 = Always.....5 = Never	NBHW survey	*Dignity*: Respect for personal integrity Self-determination Participation Individualised care
Model 4 Well-being	How safe or unsafe does it feel to live in the RCF?	Ordinal response treated as categorical variable. 1 = Very safe 2 = Quite safe 3 =Neither safe nor unsafe 4 = Quite unsafe 5 = Very unsafe	NBHW survey	*Well-being*: Safety
Model 5 Well-being	Do you feel trust in staff at the RCF?	Ordinal response treated as categorical variable. 1 = Yes, for all staff 2 = Yes, for most of the staff 3 = Yes, for some of the staff 4 = No, for none of the staff	NBHW survey	*Well-being*: Safety
Model 6 Well-being	How satisfied or dissatisfied are you with the social activities offered at the RCF?	Ordinal response treated as categorical variable. 1 = Very satisfied 2 = Quite satisfied 3 = Neither satisfied nor dissatisfied 4 = Quite dissatisfied 5 = Very dissatisfied	NBHW survey	*Well-being*: Meaningfulness

2.3.2 | Measures of independent variables

Attitudes of staff were measured using one survey question. *The care environment* was measured using four survey questions regarding the indoor-outdoor-mealtime environment. *Individual factors* were measured using two survey questions regarding self-rated health. Data on *age* and *sex* were retrieved from the patient register. Respondents with *dementia* were identified with the help of diagnostic data from the patient register using the ICD-10 codes F00-F003. Respondents with prescribed medication for dementia were in the medical register, with the code N06D, also identified as having dementia. An overview of the independent variables is presented in Table 2.

2.4 | Ethical considerations

The study was approved by a Regional Research Ethics Committee in Sweden (reg. no. 2017/140). Respondents were informed by the NBHW that their data could be used in research. Data were coded, and no respondent could be identified in this study. Ethical standards for scientific work were followed and based on The Declaration of Helsinki (The World Medical Association, 2018).

2.5 | Statistical analysis

Descriptive statistics were used to explore the characteristics of the respondents and whether they represented the underlying target population. We assumed the missingness mechanism to be completely at random (MCR, Little & Rubin, 2002). As such, the observed sample was treated as a random sample from the target population. We checked the validity of the MCR assumption by comparing the background characteristics (age, sex, prevalence of dementia) with the respective population figures using descriptive statistics. Furthermore, descriptive statistics were used to compare whether there were any differences between respondents with and without dementia and whether there were any differences between self-respondents and proxy answers. All statistical analyses were performed in R statistical software (R Core Team, 2020). Ordinal logistic regression, or proportional odds (PO), models were used to analyse the associations between the dependent and independent variables (Venables & Ripley, 2002). Each of the dependent variables (Table 1) was analysed using a separate PO model. The same independent variables (Table 2) were used in all models. Responses with the response alternative "I do not know/no opinion" were treated as missing data. All cases with missing data were excluded from the analysis. PO models were fitted by using the "polr" function from the MASS library (Venables & Ripley, 2002).

3 | RESULTS

A total of 35,432 residents responded to the survey (response rate 49%). Their ages ranged from 66 to 110 years (median 88), most of them, 69%, were women, and 19% were diagnosed with or had been prescribed medication for dementia. Of the respondents, 36% responded to the survey by themselves. Additional results about the characteristics of the respondents, differences between residents with and without dementia and the distribution of proxy answers are presented in Table 3.

Regarding aspects of dignity, 32% of the respondents were dissatisfied with information about care, while 22% were dissatisfied regarding the possibility to influence what time they received care. Regarding how their opinions and wishes were being considered in care, 6.5% of the respondents were dissatisfied. Regarding aspects of well-being, while 15% of the respondents did not feel trust for staff at the RCF, most of the respondents still reported feeling safe at the RCF, with only 4% feeling unsafe. Most of the respondents were satisfied with the offered social activities, but 11% were dissatisfied with these social activities. Additional results for the dependent and independent variables are presented in Table 4.

The results from the fitted PO models show that there were statistically significant (p-value <0.05) associations between the dependent variables and all the independent variables (except for a few). Associations between the dependent and independent variables are presented in terms of estimated (cumulative) odds ratios (CORs) and 95% confidence intervals from the PO models in Table 5. In the text below, those effects showing a 25% or higher difference in COR are reported.

3.1 | Factors associated with dignity (Models 1–3)

Attitudes of staff were associated with dignity in that respondents who had experienced any of the ten listed negative incidents had, on average, a 72% higher COR of being dissatisfied with information, a 65% higher COR of being dissatisfied with the ability to influence what time to receive care and a 232% higher COR of being dissatisfied with how their opinions and wishes were considered compared to respondents who had not experienced any of the negative incidents.

Environmental factors were associated with dignity in that respondent who did not thrive in their apartments had, on average, a 43% higher COR of being dissatisfied regarding their influence on what time to receive care and a 49% higher COR of being dissatisfied with how their opinions and wishes were considered compared to respondents who did thrive in their apartments. Regarding the common areas, respondents who did not thrive there had a 216% higher COR of being dissatisfied with information about changes in care, a 58% higher COR of being dissatisfied with the ability to influence what time to receive care and a 59% higher COR of being dissatisfied with how their opinions and wishes were considered. The same trend was found for the outdoor environment. Respondents who did not find mealtimes pleasant had a 505% higher COR of being dissatisfied with information, a 296% higher COR of being dissatisfied with the ability to influence what time to receive care and a 321% higher COR of being dissatisfied with how their opinions and

TABLE 2 Overview of the independent variables in all statistical models

Descriptions and questions	Response alternatives and measurement scales	Recoding	Source
Attitudes of staff			
Have you experienced any of the following in your contact with staff? 1. Did not show respect for your privacy, e.g., did not knock on the door before entering your room. 2. Made negative comments about you, your belongings or your home. 3. Treated you disrespectfully in words or gestures. 4. Treated you like a child. 5. Denied your wishes for the help to be received. 6. Denied your wishes at mealtimes. 7. Did not show respect in toileting, bathing and dressing. 8. Was harsh about toileting, bathing, and dressing. 9. Kept distance in nursing. 10. Acted inappropriately in any other way.	0 = Not experienced 1 = Experienced		NBHW survey
Care environment			
Do you thrive in your apartment?	Ordinal response treated as categorical variable. 1 = Yes 2 = Partly 3 = No		NBHW survey
Are the common areas pleasant?	Ordinal response treated as categorical variable. 1 = Yes.....3 = No		NBHW survey
Is the outside environment pleasant?	Ordinal response treated as categorical variable. 1 = Yes.....3 = No		NBHW survey
Do you experience mealtimes as a pleasant time of the day?	Ordinal response treated as categorical variable. 1 = Yes, always 2 = Mostly 3 = Sometimes 4 = Seldom 5 = No, never		NBHW survey
Individual factors			
Age	1 = 65–79 years 2 = 80 years and older		Patient register
Sex	1 = Male 2 = Female		Patient register
Resident diagnosed with dementia and/or prescribed medication for dementia?	0 = No 1 = Yes		Patient register Medical register
How do you rate your health?	1 = Very good 2 = Quite good 3 = Fair 4 = Quite poor 5 = Very poor	1 = Good (1, 2, 3) 2 = Poor (4, 5)	NBHW survey
How do you rate your mobility indoors?	1 = I can move around by myself without difficulties 2 = I have some difficulties moving around by myself 3 = I have major difficulties moving around by myself 4 = I cannot move around by myself	1 = Can move around by myself (1) 2 = Difficulties/ cannot move around by myself (2, 3, 4)	NBHW survey

TABLE 2 (Continued)

Descriptions and questions	Response alternatives and measurement scales	Recoding	Source
Proxy-answer			
Who answered the survey?	1 = Self 2 = Relative 3 = Friend 4 = Trustee 5 = Staff 6 = Other	1 = Self 2 = Relative/friend (2, 3) 3 = Trustee, Staff, Other (4, 5, 6)	NBHW survey

TABLE 3 Overview of characteristics of the respondents and the distribution of proxy answers

Characteristics	Frequency (%)	Frequency (%) not dementia	Frequency (%) dementia
Number of residents	35,432	28,754 (81%)	6,678 (19%)
Age			
Median (Q1–Q3)	88 (82, 93)	89 (89, 93)	86 (81, 90)
Min-max	66–110	66–110	66–105
1.65–79 2.80-	1. 5,946 (17%) 2. 29,486 (83%)	1. 4,563 (16%) 2. 24,191 (84%)	1. 1,383 (21%) 2. 5,295 (79%)
Sex			
1. Male 2. Female	1. 10,874 (31%) 2. 24,558 (69%)	1. 8,770 (31%) 2. 19,984 (69%)	1. 2,104 (32%) 2. 4,574 (68%)
Self-rated health			
1. Good 2. Poor	1. 22,444 (67%) 2. 11,288 (33%)	1. 19,278 (68%) 2. 9,131 (32%)	1. 4,424 (67%) 2. 2,157 (33%)
Self-rated mobility			
1. Can move around by myself. 2. Difficulties/cannot move around by myself	1. 5,715 (16%) 2. 29,381 (84%)	1. 3,998 (14%) 2. 24,483 (86%)	1. 1,717 (26%) 2. 4,898 (74%)
Who answered the survey?			
1. Self 2. Relatives 3. Friend 4. Trustee 5. Staff 6. Other	1. 12,620 (36%) 2. 18,676 (54%) 3. 463 (1%) 4. 3,012 (8.5%) 5. 37 (0.1%) 6. 141 (0.4%)	1. 10,886 (38.5%) 2. 14,464 (51%) 3. 401 (1.5%) 4. 2,419 (8.5%) 5. 28 (0.1%) 6. 121 (0.4%)	1. 1,734 (26%) 2. 4,212 (64%) 3. 62 (0.9%) 4. 593 (9%) 5. 9 (0.1%) 6. 20 (0.3%)

wishes were considered compared to respondents who found the mealtimes pleasant.

The factors of self-rated health, mobility and dementia were associated with dignity in that respondents who rated their health as poor had a 29% higher COR of being dissatisfied with the ability to influence what time to receive care compared to respondents who rated their health as good. Respondents with difficulties moving around by themselves had a 45% higher COR of being dissatisfied with the ability to influence what time to receive care compared to respondents who were able to move around by themselves. Respondents diagnosed with dementia, compared to respondents not diagnosed with dementia, had a 28% higher COR of being dissatisfied with the ability to influence what time to receive care. The proxy answers regarding information about care indicated that trustees, staff or others had a 27% higher COR than that of the self-respondents regarding reporting satisfaction with information. Regarding the ability to influence what time one received care, relatives had a 65% higher COR, and trustees, staff and others had an 80% higher COR of rating dissatisfaction compared to the self-respondents. Regarding how opinions and wishes were regarded, relatives (26%), friends (35%) and trustees, staff and others (55%) all had a higher COR of rating that the respondent was dissatisfied with how staff considered his or her opinions and wishes.

3.2 | Factors associated with well-being (Models 4–6)

Attitudes of staff were associated with well-being in that respondents who had experienced any of the ten negative incidents had a

TABLE 4 Frequency table for the dependent and independent variables (relative frequency in parentheses)

Data	All respondents	Non-dementia	Dementia
Dependent variables			
Dignity Do staff inform you beforehand about changes in your care? 1. 4,952 (18%) 2. 8,272 (30%) 3. 5,415 (20%) 4. 4,490 (16%) 5. 4,416 (16%)	1. 4,952 (18%) 2. 8,272 (30%) 3. 5,415 (20%) 4. 4,490 (16%) 5. 4,416 (16%)	1. 4,167 (18%) 2. 6,898 (30%) 3. 4,534 (20%) 4. 3,717 (16%) 5. 3,633 (16%)	1. 785 (17%) 2. 1,374 (30%) 3. 881 (19%) 4. 773 (17%) 5. 783 (17%)
Dignity Can you influence what time to get care? 1. 6,268 (21%) 2. 11,498 (39%) 3. 5,422 (18%) 4. 3,372 (12%) 5. 2,785 (10%)	1. 6,268 (21%) 2. 11,498 (39%) 3. 5,422 (18%) 4. 3,372 (12%) 5. 2,785 (10%)	1. 5,327 (22%) 2. 9,431 (39%) 3. 4,447 (18%) 4. 2,782 (12%) 5. 2,246 (9%)	1. 941 (18%) 2. 2,067 (40%) 3. 975 (19%) 4. 590 (12%) 5. 539 (11%)
Dignity Do staff consider your opinions and wishes regarding your care? 1. 9,465 (32%) 2. 14,024 (47%) 3. 4,368 (14.5%) 4. 1,381 (4.5%) 5. 628 (2%)	1. 9,465 (32%) 2. 14,024 (47%) 3. 4,368 (14.5%) 4. 1,381 (4.5%) 5. 628 (2%)	1. 7,867 (32%) 2. 11,380 (46%) 3. 3,584 (15%) 4. 1,156 (5%) 5. 529 (2%)	1. 1,598 (30%) 2. 2,644 (49%) 3. 784 (15%) 4. 225 (4%) 5. 99 (2%)
Well-being How safe or unsafe does it feel to live in the RCF? 1. 16,833 (50%) 2. 12,646 (38%) 3. 2,683 (8%) 4. 1,008 (3%) 5. 344 (1%)	1. 16,833 (50%) 2. 12,646 (38%) 3. 2,683 (8%) 4. 1,008 (3%) 5. 344 (1%)	1. 13,662 (50%) 2. 10,290 (38%) 3. 2,202 (8%) 4. 832 (3%) 5. 278 (1%)	1. 3,171 (51%) 2. 2,356 (37.5%) 3. 481 (7.5%) 4. 176 (3%) 5. 66 (1%)
Well-being Do you feel trust in staff at the RCF? 1. 13,612 (40%) 2. 15,067 (45%) 3. 4,772 (14%) 4. 226 (1%)	1. 13,612 (40%) 2. 15,067 (45%) 3. 4,772 (14%) 4. 226 (1%)	1. 10,972 (40%) 2. 12,296 (45%) 3. 3,919 (14%) 4. 188 (1%)	1. 2,640 (42%) 2. 2,771 (44%) 3. 853 (13%) 4. 38 (1%)
Well-being How satisfied or dissatisfied are you with the social activities offered at the RCF? 1. 7,000 (25%) 2. 11,142 (39%) 3. 7,040 (25%) 4. 2,093 (7%) 5. 1,269 (4%)	1. 7,000 (25%) 2. 11,142 (39%) 3. 7,040 (25%) 4. 2,093 (7%) 5. 1,269 (4%)	1. 5,718 (25%) 2. 9,069 (39%) 3. 5,659 (25%) 4. 1,660 (7%) 5. 994 (4%)	1. 1,282 (24%) 2. 2,073 (38%) 3. 1,381 (25%) 4. 433 (8%) 5. 275 (5%)
Independent variables			
Attitudes from staff Have you experienced any negative incidents in your contact with staff? 1. Not experienced 2. Experienced 1. 24,635 (76%) 2. 7,747 (24%)	1. 24,635 (76%) 2. 7,747 (24%)	1. 19,929 (75%) 2. 6,488 (25%)	1. 4,706 (79%) 2. 1,259 (21%)
Care environment Do you thrive in your apartment? 1. 24,501 (74%) 2. 7,476 (23%) 3. 1,169 (3%)	1. 24,501 (74%) 2. 7,476 (23%) 3. 1,169 (3%)	1. 19,869 (74%) 2. 6,110 (23%) 3. 978 (3%)	1. 4,632 (75%) 2. 1,366 (22%) 3. 191 (3%)
Care environment Do you thrive in the common areas? 1. 20,919 (64%) 2. 9,909 (30%) 3. 2,038 (6%)	1. 20,919 (64%) 2. 9,909 (30%) 3. 2,038 (6%)	1. 16,846 (64%) 2. 8,066 (30%) 3. 1,665 (6%)	1. 4,073 (65%) 2. 1,843 (29%) 3. 373 (6%)
Care environment Do you thrive in the outdoor environment? 1. 19,780 (66%) 2. 8,054 (27%) 3. 2,119 (7%)	1. 19,780 (66%) 2. 8,054 (27%) 3. 2,119 (7%)	1. 15,956 (66%) 2. 6,483 (27%) 3. 1,711 (7%)	1. 3,824 (66%) 2. 1,571 (27%) 3. 408 (7%)
Care environment Are mealtimes a pleasant time? 1. 7,121 (22%) 2. 14,795 (46%) 3. 6,647 (21%) 4. 2,522 (8%) 5. 968 (3%)	1. 7,121 (22%) 2. 14,795 (46%) 3. 6,647 (21%) 4. 2,522 (8%) 5. 968 (3%)	1. 5,627 (22%) 2. 11,864 (46%) 3. 5,512 (21%) 4. 2,180 (8%) 5. 849 (3%)	1. 1,494 (25%) 2. 2,931 (48%) 3. 1,135 (19%) 4. 342 (6%) 5. 119 (2%)
Individual factor How do you rate your health? 1. 1,258 (4%) 2. 8,260 (24%) 3. 14,184 (40%) 4. 8,329 (24%) 5. 2,959 (8%)	1. 1,258 (4%) 2. 8,260 (24%) 3. 14,184 (40%) 4. 8,329 (24%) 5. 2,959 (8%)	1. 993 (3.5%) 2. 6,650 (23%) 3. 11,635 (41%) 4. 6,705 (24%) 5. 2,426 (8.5)	1. 265 (4%) 2. 1,610 (24%) 3. 2,549 (39%) 4. 1,624 (25%) 5. 533 (8%)

TABLE 4 (Continued)

Data	All respondents	Non-dementia	Dementia
Individual factor How do you rate your health?	1,2,3: 22,444 (67%) 4,5: 11,288 (33%)	1,2,3: 19,278 (68%) 4,5: 9,131 (32%)	1,2,3: 4,424 (67%) 4,5: 2,157 (33%)
Individual factor How do you rate your mobility indoors?	1. 5,715 (16%) 2. 13,048 (37%) 3. 7,285 (21%) 4. 9,048 (26%)	1. 3,998 (14%) 2. 10,585 (37%) 3. 6,149 (22%) 4. 7,749 (27%)	1. 1,717 (26%) 2. 2,463 (37%) 3. 1,136 (17%) 4. 1,299 (20%)
Individual factor How do you rate your mobility indoors?	1: 5,715 (16%) 2,3,4: 29,381 (84%)	1: 3,998 (14%) 2,3,4: 24,483 (86%)	1: 1,717 (26%) 2,3,4: 4,898 (74%)

201% higher COR of feeling unsafe at the RCF, a 269% higher COR of not trusting staff and a 30% higher COR of being dissatisfied with social activities compared to respondents who had not experienced any of the negative incidents.

Environmental factors were associated with well-being in that respondents who did not thrive in their apartments had a 565% higher COR of feeling unsafe at the RCF and a 207% higher COR of not trusting staff compared to respondents who did thrive in their apartments. Respondents who did not thrive in their apartments also had a 71% higher COR of being dissatisfied with the offered social activities. Respondents who did not thrive in the common areas had a 236% higher COR of feeling unsafe, a 230% higher COR of not trusting staff at the RCF and a 380% higher COR of being dissatisfied with the offered social activities. The same trend was found for the outdoor environment. Respondents who did not find mealtimes pleasant had a 304% higher COR of feeling unsafe at the RCF, a 313% higher COR of not trusting staff and a 411% higher COR of being dissatisfied with the social activities compared to respondents who found the mealtimes pleasant.

Health was associated with well-being in that respondents who rated their health as poor had a 30% higher COR of not feeling safe at the RCF and a 27% higher COR of being dissatisfied with the offered social activities compared to respondents who rated their health as good. Dementia was associated with well-being, as respondents diagnosed with dementia had a 25% higher COR of being dissatisfied with social activities compared to respondents not diagnosed with dementia. The proxy answers indicated that relatives had a 29% higher COR rating of the respondents being dissatisfied with social activities compared to the self-respondents.

4 | DISCUSSION

Our results have important implications for care, as they show what factors are associated with and could be targeted to promote dignity and well-being for older people living in RCFs. In this study, our hypothesis was confirmed, as the results show that perceptions of negative attitudes of staff and not thriving in the indoor-outdoor-mealtime environment were associated with lower satisfaction of dignity and well-being. These results also verify the PCP framework. In addition, our hypothesis was confirmed regarding individual factors in that perceived poor health and/or dementia were associated with lower satisfaction of dignity and well-being.

Our results show that there were statistically significant associations between the attitudes of staff and dignity and well-being. Residents who had experienced a disrespectful attitude from staff had higher odds of being dissatisfied with dignity and well-being than their counterparts, especially in regard to how their opinions and wishes were considered in care, feeling safe and trusting staff at the RCF. These results are verified by the PCP framework, which indicates that the attitudes of staff are prerequisites that need to be considered as a first step to achieve person-centred outcomes (Centre for Person-centred Practice Research, 2021; McCormack & McCance, 2006). In addition, our results for the proxy answers show that staff had higher odds of reporting that residents were satisfied with aspects of dignity and well-being than those reported by the residents themselves. As PCC implies seeing a person as someone with individual needs and preferences (Edvardsson, 2015; Pope, 2012), our results regarding the different preferences between residents and staff are important. As the survey instructions to the proxies were to respond to the survey in a way that reflected the residents' perceptions, these results could be interpreted as staff sometimes lacking the skills to take part in and to reflect on residents' preferences. This interpretation is verified by the PCP framework, which suggests that developing skills to communicate with others is important, as doing so shows concern for people's situations and an interest in finding mutual solutions (Centre for Person-centred Practice Research, 2021; McCormack & McCance, 2006). According to the framework, our results can be interpreted as staff needing to develop their skills regarding communication, as improved communication skills seem to be crucial to better take care of residents' own preferences regarding dignity and well-being.

Regarding the indoor-outdoor environment, our results show statistically significant associations with dignity and well-being, as residents who reported not thriving in the environment had higher odds of being dissatisfied with dignity and well-being compared to their counterparts. These results are verified by the PCP framework, which suggests that the care environment influences the ability to achieve person-centred outcomes. According to the framework, a physical environment that aims to promote dignity, privacy, choice/

TABLE 5 Cumulative odds ratio (COR), in inverse scale, and confidence intervals (CI) from the six models

	Dependent variables					
	Model 1 Do staff inform you beforehand about changes in your care? (*N* = 20,487)	Model 2 Can you influence what time to get care? (*N* = 21,580)	Model 3 Do staff consider your opinions and wishes regarding your care? (*N* = 22,029)	Model 4 How safe or unsafe does it feel to live in the facility? (*N* = 23,703)	Model 5 Do you feel trust in the staff at the facility? (*N* = 23,729)	Model 6 How satisfied or dissatisfied are you with the social activities provided at the facility? (*N* = 21,591)
Independent variables	COR (CI)	COR (CI)	COR (CI)	COR (CI)	COR (CI)	COR (CI)
Attitudes of staff						
Have you experienced any negative incidents in your contact with staff? Not experienced	Ref	Ref	Ref	Ref	Ref	Ref
Experienced	1.72 (1.60, 1.84)[a]	1.65 (1.54, 1.77)[a]	2.32 (2.15, 2.51)[a]	2.01 (1.86, 2.16)[a]	2.69 (2.49, 2.91)[a]	1.30 (1.21, 1.40)[a]
Care environment						
Do you thrive in your room or apartment? Yes	Ref	Ref	Ref	Ref	Ref	Ref
Partly	1.08 (1.01, 1.16)[a]	1.33 (1.24, 1.42)[a]	1.44 (1.34, 1.54)[a]	2.32 (2.16, 2.50)[a]	1.42 (1.32, 1.53)[a]	1.40 (1.31, 1.50)[a]
No	1.18 (0.99, 1.40)	1.43 (1.22, 1.67)[a]	1.49 (1.26, 1.76)[a]	5.65 (4.77, 6.68)[a]	2.07 (1.71, 2.49)[a]	1.71 (1.45, 2.06)[a]
Are the common areas pleasant? Yes	Ref	Ref	Ref	Ref	Ref	Ref
Partly	1.47 (1.37, 1.57)[a]	1.15 (1.08, 1.23)[a]	1.32 (1.23, 1.41)[a]	1.64 (1.53, 1.76)[a]	1.60 (1.49, 1.72)[a]	1.84 (1.72, 1.97)[a]
No	2.16 (1.89, 2.47)[a]	1.58 (1.39, 1.80)[a]	1.59 (1.38, 1.82)[a]	2.36 (2.06, 2.71)[a]	2.30 (1.98, 2.66)[a]	3.80 (3.31, 4.35)[a]
Is the outside environment pleasant? Yes	Ref	Ref	Ref	Ref	Ref	Ref
Partly	1.23 (1.16, 1.31)[a]	1.33 (1.25, 1.41)[a]	1.37 (1.28, 1.46)[a]	1.40 (1.31, 1.50)[a]	1.20 (1.19, 1.28)[a]	1.71 (1.61, 1.82)[a]
No	1.82 (1.62, 2.04)[a]	1.66 (1.49, 1.85)[a]	1.40 (1.24, 1.57)[a]	1.50 (1.33, 1.68)[a]	1.40 (1.24, 1.58)[a]	2.36 (2.10, 2.64)[a]
Do you experience mealtimes as a pleasant time of the day? Yes, always	Ref	Ref	Ref	Ref	Ref	Ref
Mostly	1.75 (1.63, 1.87)[a]	1.80 (1.68, 1.93)[a]	1.95 (1.81, 2.09)[a]	1.81 (1.66, 1.98)[a]	2.12 (1.96, 2.29)[a]	2.13 (1.98, 2.28)[a]
Sometimes	2.35 (2.14, 2.59)[a]	2.29 (2.08, 2.51)[a]	2.37 (2.14, 2.62)[a]	2.28 (2.05, 2.53)[a]	2.55 (2.30, 2.83)[a]	2.80 (2.54, 3.08)[a]
Seldom	3.07 (2.69, 3.49)[a]	2.41 (2.12, 2.75)[a]	2.68 (2.34, 3.09)[a]	2.56 (2.22, 2.95)[a]	2.66 (2.30, 3.07)[a]	3.29 (2.87, 3.76)[a]
No, never	5.05 (4.10, 6.23)[a]	2.96 (2.42, 3.62)[a]	3.21 (2.61, 3.96)[a]	3.04 (2.46, 3.75)[a]	4.10 (3.33, 5.07)[a]	4.11 (3.33, 5.07)[a]

TABLE 5 (Continued)

	Dependent variables					
	Model 1 Do staff inform you beforehand about changes in your care? (*N* = 20,487)	Model 2 Can you influence what time to get care? (*N* = 21,580)	Model 3 Do staff consider your opinions and wishes regarding your care? (*N* = 22,029)	Model 4 How safe or unsafe does it feel to live in the facility? (*N* = 23,703)	Model 5 Do you feel trust in the staff at the facility? (*N* = 23,729)	Model 6 How satisfied or dissatisfied are you with the social activities provided at the facility? (*N* = 21,591)
Individual factors						
Age: 65–79	Ref	Ref	Ref	Ref	Ref	Ref
Age: 80-	1.11 (1.03, 1.19)[a]	1.11 (1.03, 1.19)[a]	1.06 (0.98, 1.14)	0.94 (0.87, 1.02)	0.93 (0.86, 1.01)	0.93 (0.86, 0.99)[a]
Gender: Male	Ref	Ref	Ref	Ref	Ref	Ref
Gender: Female	0.97 (0.92, 1.03)	1.00 (0.95, 1.06)	0.90 (0.85, 0.96)[a]	0.94 (0.88, 1.00)	0.98 (0.92, 1.04)	0.80 (0.76, 0.85)[a]
Non-dementia	Ref	Ref	Ref	Ref	Ref	Ref
Dementia	1.21 (1.13, 1.30)[a]	1.28 (1.20, 1.36)[a]	1.19 (1.11, 1.28)[a]	1.14 (1.06, 1.22)[a]	1.08 (1.01, 1.16)[a]	1.25 (1.17, 1.33)[a]
Self-rated health: Good health	Ref	Ref	Ref	Ref	Ref	Ref
Poor health	1.08 (1.02, 1,15)[a]	1.29 (1.22, 1.37)[a]	1.18 (1.10, 1.26)[a]	1.30 (1.21, 1.39)[a]	1.20 (1.13, 1.29)[a]	1.27 (1.19, 1.35)[a]
Self-rated mobility: Can move around	Ref	Ref	Ref	Ref	Ref	Ref
Difficulties/cannot move around	1.11 (1.05, 1.18)[a]	1.45 (1.37, 1.53)[a]	1.19 (1.12, 1.26)[a]	0.97 (0.91, 1.03)	1.06 (1.00, 1.13)	1.06 (1.00, 1.12)[a]
Self-report	Ref	Ref	Ref	Ref	Ref	Ref
Proxy: Relatives	1.04 (0.98, 1.09)	1.65 (1.56, 1.74)[a]	1.26 (1.19, 1.33)[a]	0.96 (0.90, 1.02)	1.06 (0.99, 1.13)	1.29 (1.22, 1.36)[a]
Proxy: Friend	0.86 (0.69, 1.07)	1.07 (0.85, 1.34)	1.35 (1.06, 1.72)[a]	1.03 (0.80, 1.32)	0.88 (0.68, 1.14)	1.00 (0.79, 1.27)
Proxy: Trustee, staff, other	0.73 (0.66, 0.81)[a]	1.80 (1.64, 2.00)[a]	1.55 (1.39, 1.72)[a]	0.86 (0.77, 0.96)[a]	1.00 (0.89, 1.11)	1.18 (1.07, 1.30)[a]

Note: *N* = Observations.

[a]Significant at a level of 5%.

control and safety is a central component in the care environment (Centre for Person-centred Practice Research, 2021; McCormack & McCance, 2006). The importance of a supportive physical environment for providing PCC has also been highlighted in previous research (Sjögren et al., 2017). From this study, we know that there are associations between the physical environment and dignity and well-being, but we do not know what factors in the physical environment do not promote dignity and well-being. Is there a lack of privacy or a lack of choice and control in the physical environment at RCFs? According to the PCP framework, knowledge of these factors is important for staff, as the care environment influences person-centred care processes, which in turn affect the possibility of achieving person-centred outcomes (Centre for Person-centred Practice Research, 2021; McCormack & McCance, 2006). With regard to well-being, our results show that residents who did not thrive in the environment had higher odds of feeling unsafe at the RCF. Regarding safety, previous research has noted that staff mainly focus on preventing risks in the care environment (Abbott et al., 2016; Chaudhury et al., 2016; Lette et al., 2020; Ross et al., 2015; Saarnio et al., 2019; van der Cingel et al., 2016). This raises the following question: If staff focus on preventing risks in the care environment, how can it be that residents feel unsafe? One possible interpretation could be that residents and staff have different preferences regarding safety. Residents have noted that to feel safe, it is important to be seen as an individual and to be treated based on their individual needs (Edvardsson, 2008; Kristensson et al., 2010; van der Cingel et al., 2016); furthermore, not having control in a situation can cause the perception of a lack of safety (Saarnio et al., 2016, 2019).

Our results show statistically significant associations between the mealtime environment and dignity and well-being. Residents who did not find the mealtime to be a pleasant time of day had higher odds of being dissatisfied with dignity and well-being than their counterparts. Previous research shows that food intake at RCFs is affected by the dining environment and social interactions at mealtimes (Keller et al., 2015). However, the use of environmental and social strategies to promote food intake is fairly low (Milte et al., 2018). From this study, we know that there are associations between dignity and well-being and the mealtime environment, but we do not know what factors in the mealtime environment affect dignity and well-being. Previous research aiming to implement nutritional guidelines, including the meeting and the atmosphere at RCFs, has shown positive effects regarding the experience of mealtimes (Törmä et al., 2018). To improve the mealtime environment and to promote dignity and well-being, it is important to include aspects other than just the physical environment. The meeting and the atmosphere also affect the mealtime experience.

In the PCP framework, there is no construct regarding the characteristics of residents and relationships with the constructs in the framework. However, in this study, we found that residents who perceived poor health, poor mobility and dementia had higher odds of being dissatisfied with dignity and well-being than their counterparts. Similar results have been found in previous research in which older people diagnosed with dementia who received home-care services experienced more dissatisfaction regarding dignity than did older people not diagnosed with dementia (Hammar et al., 2020). On the one hand, our results indicate that these factors are important for promoting dignity and well-being. On the other hand, our results should be interpreted carefully, as our analysis indicated that the proxy ratings regarding health and mobility differed in that the proxies in this study rated health and mobility poorer than the self-respondents themselves did; this phenomenon regarding proxy ratings has also been found in previous research (O'Shea et al., 2020). As our results regarding the associations between health, mobility and dementia need to be interpreted carefully due to the use of proxy ratings, more research is needed in this area.

4.1 | Implications for practice and policy

Based on our results, we suggest that to promote dignity and well-being, it is important to be aware of associated factors, including (a) the attitudes of staff, (b) the indoor-outdoor-mealtime environment and (c) the improvement of care based on these factors. When improving care, it is important that residents and staff work together and discuss their different preferences. According to our results, we further suggest that there is a need for interventions targeting staff attitudes and the indoor-outdoor-mealtime environment. As dignity and well-being are associated with both the attitudes of staff and the care environment, we suggest that the PCP framework could be used as a theoretical framework for these interventions, as it takes into consideration both the attitudes of staff and the care environment.

4.2 | Strengths and limitations

When interpreting these findings, it should be noted that due to the nonexperimental design, the effects estimated using observational data may not be interpreted as causal effects. One strength of this study is the use of a large amount of national data, and the response rate was 49%. We have no knowledge of the nonrespondents, and we assumed the nonresponse mechanism to be MCR; however, this assumption was not statistically testable. Nonetheless, the results could be generalisable, as we from the descriptive statistics did not find a strong indication regarding a possible violation of this assumption. The characteristics of the respondents did not indicate any differences from those of the target population, as reported elsewhere (Odzakovic et al., 2019; The Swedish National Board of Health & Well-fare, 2019c). Regarding dementia, it has been reported that approximately 67% of older people living in RCFs have cognitive impairments (Björk et al., 2016). In this study, only 19% of the respondents were diagnosed with or had medication for dementia, which might be a limitation regarding generalizability. However, the low prevalence of dementia can be explained by a previous study reporting that 71% of the residents in a sample had cognitive impairments, but only 40% of them were diagnosed with

dementia (Ernsth Bravell et al., 2011). Even though only 19% of the respondents in this study were diagnosed with/had prescribed medication for dementia, our results indicate that dementia was associated with higher odds of being dissatisfied with dignity and well-being. This association is important to be aware of to improve care for persons with dementia. However, because only 19% of the respondents in this study had dementia, more studies are needed in this area. Furthermore, every self-reported study is subject to possible response (e.g. lack of memory) bias. This may be an issue for this study because the respondents were older people, and some of them had been diagnosed with dementia. Approximately one-third of the respondents responded to the survey independently, and the rest of the responses were proxy answers. Although the information provided to the proxies asked them to respond to the survey in a way that reflected the residents' perceptions, there might be a risk that they answered in a way that reflected their own perceptions. Thus, this might be a bias in this study. However, our analysis indicated that there were no differences, except for self-rated health and self-rated mobility, between the proxy answers and the self-respondents. Because a scientific investigation on the validity of the measures is missing, in our interpretation of the results, we refrained from interpreting the estimated degree of association as the relationship of the independent variable with the underlying concept. Rather, we interpreted the results as the observed association between the dependent variables and the independent variables, and we pointed out that the dependent variables, as per the legislation, can be treated as the measures of dignity and well-being. Despite these limitations, the use of national data in this study can provide meaningful evidence for quality improvements.

5 | CONCLUSION

The attitudes of staff, indoor-outdoor-mealtime environments and poor health/dementia are factors associated with perceptions of dignity and well-being. To promote dignity and well-being, there is a need to be aware of and improve these associated factors. As dignity and well-being are central values in the care of older people worldwide, the results can be generalised to other care settings for older people in countries outside of Sweden. The results of this study can be used when discussing associated factors and the different preferences of staff and residents. To promote dignity and well-being in care, the PCP framework could be used as a theoretical framework by taking into account the attitudes of staff and the care environment when designing future interventions.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

AUTHOR CONTRIBUTIONS

Study design: CR, MA, AS, A-M B, L M-H. Data collection: L M-H was responsible for data withdrawal from the NBHW. Analysis: CR and MA conducted the analysis. AS, A-M B, and L MH reviewed and commented on the analysis. Drafting of the article: CR drafted the article, and MA, AS, A-M B and L MH reviewed and commented on drafts of the manuscript. All authors read and approved the final version of the manuscript.

DATA AVAILABILITY STATEMENT

Data available on request from the authors.

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