Challenging Behaviors as a Relational Phenomenon: Findings From a Qualitative Study in a Nursing Home in Norway

Mai Camilla Munkejord[1] (iD) and Laila Tingvold[2]

Abstract

Challenging behaviors are common in nursing homes. Drawing on rich qualitative data from fieldwork and in-depth interviews with staff in a nursing home in Norway, we will explore (a) how challenging behaviors unfolded, and (b) how such incidents were handled and talked about among staff. Our data is presented firstly through Anna's story as an introduction to discussing: (1) the problem of contrasting approaches to avoid challenging behaviors and (2) the importance of knowing the resident. Christopher's story then works as an introduction to discuss (3) the importance of understanding how to prioritize, (4) the importance of caring with connection and concern, and (5) the importance of sharing success stories among staff. In conclusion we argue that we should develop a more flexible organizational culture and a staffing practice in which care workers are empowered to use their discretion and thus to care for the residents with more connection and sensitivity than is currently the case.

Introduction

Challenging behaviors among nursing home residents are common in Norway, as elsewhere in the Western world. Challenging behavior includes actions that are harmful to care workers and other residents on the ward. The most common forms are self-injury, attacking others (aggression), destruction, unacceptable social and sexual conduct, screaming, restless walking, non-compliance, and inappropriate toileting (Stokes, 2017). Research from different parts of the world indicates that nursing home residents with challenging behaviors are more likely to be restrained (Øye et al., 2017) and, also, to be treated with antipsychotic medications or sedatives (Voyer et al., 2005). How to deal with and reduce challenging behaviors among nursing home residents is a demanding task for nursing home staff.

It is important to understand, as Legere et al. (2018, p. e1361) remind us, that challenging behaviors "are often normal responses to stress and uncertainty rather than neuro-pathology." These behaviors, they continue, "can result from a number of factors related to unmet needs, including individualistic, social and organisational contexts that are not exclusive to dementia." Another term to describe this phenomenon, therefore, is responsive behaviors (Walsh et al.,

2021). A Canadian study found that "poor staffing," for example, too few care workers on duty, but also a high staff turnover, resulted in rushed and depersonalized care, which, in turn, resulted in an increase in challenging behaviors among residents (Morgan et al., 2008). Cassie (2012, p. 716), moreover, argues that a poor organizational culture may reduce the ability among care workers to collaborate and use professional discretion, which, in turn, may increase the prevalence of challenging behaviors. To advance this argument, Glisson et al. (2008) make the distinction between "rigid" and "proficient" organizational cultures. In a highly rigid organizational culture, care workers are expected to follow the procedures that indicate how various tasks are to be accomplished. In such an environment, the same steps are expected to be followed every time a certain task is to be carried out. In a highly proficient or flexible organizational

---
[1]Western Norway University of Applied Sciences (HVL), Bergen, Norway
[2]Norwegian University of Science and Technology (NTNU), Gjøvik, Norway

Corresponding Author:
Mai Camilla Munkejord, Centre for Care Research, West, Western Norway University of Applied Sciences, PO. Box 7030, Bergen 5020, Norway.
Email: mcmu@hvl.no

culture, on the other hand, care workers are expected to place the well-being of the resident above predefined procedures. Rather than doing things in exactly the same way every time, care workers are expected to use discretion and base their decisions on the shared knowledge about how to provide the best possible services to the different residents on the ward. This description of a highly flexible organizational culture resembles patient-centered care (PPC), which is a sociopsychological care approach that recognizes the individuality of each patient (McCormack, 2004; McCormack & McCane, 2017). In clinical settings, such as in nursing homes, PCC includes incorporating personal knowledge of the person with dementia, conducting meaningful activities and improve the quality of the relationships between the care staff and the individual with dementia (Brooker, 2003; Kitwood & Bredin, 1992). A systematic review and meta-analysis showed that PCC interventions reduced agitation, neuropsychiatric symptoms, and depression and improved the quality of life (Kim & Park, 2017). The same review stated that an educational strategy supporting learning and skill development of care staff is needed to ensure the sustainability of the effects of behavioral problems.

Some studies focus on the importance of staff having the highest possible formal education in nursing and medical sciences in order to reduce the occurrence of challenging behaviors in nursing home residents. While it may be important for the staff to have some knowledge about the various medical diagnoses of the nursing home residents and their symptoms, in this article, we advance a non-pharmacological approach to deepen our understanding of challenging behavior as a relational phenomenon. This is an approach where we understand challenging behaviors not as a sign of an illness that should be treated by medication, but rather as sign of an underlying unmet need that should be met by care staff members by use of a PCC approach highlighting connection and concern for each resident. The significance of such an approach is confirmed by Kales et al. (2015) who found that nurses often opt for drugs to sedate the person with challenging behaviors, rather than opting for non-pharmacological PCC interventions. This was also confirmed by a recent literature review by Walsh et al. (2021) who in addition found that we have very little knowledge about nurses' decision-making regarding the use of psychotropic medication to persons with dementia.

Challenging behaviors reduce the well-being of both co-residents and the care workers, and escalating situations present staff with several ethical, moral, professional, and legal challenges (Gjerberg et al., 2015). Thus, in this article, drawing on rich qualitative data from fieldwork and in-depth interviews in a nursing home in Norway, we will explore the following research questions: (a) how did challenging behaviors unfold? and (b) how were such incidents handled and talked about among staff? In conclusion, based on our findings, we argue that it is important to develop a more proficient and flexible organizational culture and a staffing practice in which care workers are empowered to use their discretion and thus to care for the residents with more connection and sensitivity than is currently the case.

Methods

In order to answer our research questions, a qualitative research design grounded in an ethnographic approach including both participant observation and in-depth interviews was used.

Participant Observation

When doing participant observation, one may in principle do anything from "nonparticipation" where the researcher is a detached observer, to a complete immersion in the environment where the study is done, often called a "complete participation" (Spradley, 1980, pp. 58–61). In practice, the researcher often enters a role somewhere in between these extremes, which was also the case in this study: For a period of 2 months, upon agreement with the manager, staff members, residents, and/or their guardians, LT engaged in activities in the ward including in social activities, meals, and conversations. In addition, the researcher was sometimes invited to help out with basic care tasks. In other words, we did what can be called an open and active type of participant observation with the aim of engaging in activities going on in the nursing home, and, through both observations and personal engagement, truly understanding what was going on (Spradley, 1980, p. 58), for example, how challenging behaviors unfolded, how care workers handled such behaviors, and how they tried to reduce their occurrence. After each day of participant observation, the researcher noted events and conversations as thoroughly as possible and reflected on how these observations could be understood.

Participants and Data Collection

In addition to the field notes from the observations, 17 care workers were interviewed (of a total of 50 employees in the nursing home). The interviewees were approached for interviews in order to shed light on employee experiences from different staff positions. The 17 interviewees thus had different educational backgrounds and varying employment arrangements; they included registered nurses with specializations in gerontology and auxiliary nurses working full-time or close to full-time, as well as unskilled care workers with no formal education in temporary part-time positions. Participants had ethnic minority and majority backgrounds, with long and short experience of long-term care work. All staff members who were invited for an interview agreed to participate. The interviews focused on the participants' experiences and perceptions of challenging behavior on the ward.

Questions asked were for instance: Have you experienced challenging behaviors among residents in the ward recently? Can you please describe what happened? How was the situation solved? What happened after? Do different staff members have different strategies regarding how to solve this kind of situations?

The interviews were performed in a room made available for the research project. Some interviews were performed prior to or after a work shift, and others during the shift on calm days when a colleague could cover the tasks and responsibilities of the interviewee during the time of the interview. All interviews were conducted in Norwegian language. The recordings from the interviews lasted from 38 to 75 minutes, depending on how much information the participants shared. All interviews were audiotaped and transcribed verbatim.

Data Analysis

LT's ethnographic descriptions of situations of challenging behavior in the nursing home during the fieldwork, as well as the interview transcripts commenting on these or other incidents of challenging behavior, were analyzed using a reflexive thematic approach (Braun & Clarke, 2006, 2019). This means that we read the data, reflected on them, wrote an overview over themes and subthemes, wondered if this overview was meaningful or not, we talked, and decided to change our themes, and then collaborated on writing the result section, discussion, and conclusion. More specifically, we did a reflexive thematic analysis grounded in the data (Braun & Clarke, 2019, p. 332). This entails that the themes were an outcome of the coding process. First, the authors obtained an overview of our data (data familiarization). Second, we performed systematic coding, which enabled us to obtain an overview of (a) the various kinds of challenging behaviors that took place, (b) which residents were involved in challenging behaviors, (c) situations preceding challenging behaviors, (d) how such situations were managed there and then, and (e) how such situations were talked about among staff when the incident had been resolved. Based on this coding, themes and subthemes were generated that enabled us to shed light on our research questions. After revisions, we decided to present the data through two stories, illustrating how challenging behaviors unfolded on the ward. Anna's story functions as an introduction to discussing the two following themes: (a) the problem of contrasting approaches to avoid challenging behaviors and (b) the importance of knowing the resident. Christopher's story works as an introduction to discuss the following themes: (c) the importance of understanding how to prioritize, (d) the importance of caring with connection and concern, and (e) the importance of sharing success stories among staff. More generally, based on an overall analysis of both the observation data and the interview data, we found that the staffing practices in this nursing home seem to be one of the main causes for the occurrence of challenging behavior. The authors are named in alphabetical order.

Ethical Consideration

A meeting was held prior to the study where the manager and most of the staff members were present. During this meeting, the researcher shared information about the aim of the study, and specifically asked for permission to do participant observation and to interview staff members about their experiences regarding how to deal with challenging behavior among residents. Staff members were invited to ask questions and share their views on the study. The staff members confirmed the relevance of the study and welcomed the researcher to take part in the everyday life of the ward for a period of 2 months. Before the fieldwork started, moreover, the researcher contacted family members (e.g., the partner or an adult child) of the residents in the nursing home ward by letter, and a week later, by phone to check if they had received the information letter and to ask if they allowed their relative to take part in the planned study through participant observation. Most family members agreed and signed a letter of consent. Some family members, however, were not reachable. The researcher thus made sure not to take any notes of situations involving those residents to the extent possible.

The participants were informed of their right to withdraw from the study without stating a reason, and they were assured that confidentiality would be maintained both in the transcribed data (that were systematically anonymized) as well as in publications coming out of the study. The study, including interviews and fieldwork in the selected nursing home, was approved by the Norwegian Center for Research Data before data gathering commenced [53138].

Results

Nursing home staff generally include a mixture of formally skilled and unskilled workers. The "skilled" care workers employed in nursing homes in Norway are mostly registered and auxiliary nurses. The category of "unskilled" care workers in Norway generally includes students working part-time, as well as persons who may have several years of practical experience but no formal education in nursing or care work. It should be added that an increasing share of both skilled and unskilled nursing home staff are of a migrant background, including labor migrants, refugees, and love migrants, who have joined their partner living in Norway (Tingvold & Fagertun, 2020). Due to current staffing practices and high levels of sick leave among staff in nursing homes, there is a substantial and increasing use of temporary workers in small part-time positions. Most of these temporary workers are unskilled care workers of migrant background who often have some challenges related to mastering the Norwegian language.

Anna's Story

Anna is a woman in her 80s who has lived in the nursing home for almost 2 years. One morning, the researcher noticed that, after eating her breakfast, Anna wandered around the corridor, apparently a bit confused. She got hold of one of the care workers and asked, "Why am I here? Can you please help me to get home?" The care worker looked at her, greeted her, and invited her to sit down with the other residents to drink coffee but avoided answering her questions. Anna asked the same questions again and again in an increasingly louder voice, but the care worker, rather than answering her question, just mumbled "You live here now" and left Anna behind while she herself entered the living room where she started to clean a table. Anna, increasingly upset, repeated her questions but was now ignored. Suddenly, Anna furiously screamed out loud: "Is there anyone who can help me phone someone to get me out of here?" Everyone froze. The other residents looked at her. All conversation stopped. Anna continued to scream and angrily threw her glasses on the floor. A second later, another care worker, who probably had overheard the escalating situation from another part of the ward, appeared. She moved slowly in the direction of Anna, looked at her, called her by her name, and asked in a mild voice if she could help her. The conversation between them developed like this:

Anna: "Why am I here?" [Upset, shouts angrily]
Care worker: "You have been here for almost two years now. Do you remember when you came here?"
Anna: "I don't remember anything! I have a house of my own, don't I?" [shouting, confused]
Care worker: "You had a very pretty house, Anna. However, you had to move here when [name of husband] died."
Anna: "Oh. . . My husband, did he really die?"
Care worker: "Yes, I'm so sorry. He passed away two years ago."

The researcher observed how Anna felt the pain of having lost her husband and her house and, thereafter, how Anna started to calm down. The care worker was by her side all the time, calmly supporting and comforting her by saying that she was so sorry that Anna's husband had passed away. Anna wept for a while, the nurse by her side talked calmly with her and continued to comfort her. After a while, the nurse reminded Anna of her son, who used to come and visit her. Anna then remembered her son with joy and, together, Anna and the care worker walked out of the living room to inspect the garden outside, one of Anna's favorite activities.

The problem of contrasting approaches to avoid challenging behaviors. Among the nursing home staff, Anna was talked about as a "true nut." When she became angry, helping her to calm down was often quite difficult. The researcher soon discovered that the staff seemed to have at least two different and sometimes conflicting approaches to handling her confusion. For example, one care worker explained that she did not have a fixed way of answering Anna's questions but admitted that she often tried a "white lie," hoping to calm her down by replying positively to Anna's question about going home, for example, telling her that she would be able to go home to her house the next morning. She explained:

> Because the next day, they [residents] have forgotten what I said anyway, so one can nearly promise things in the evening without doing something wrong. There was a time when we were asked to bring the residents "back to reality", you know, that we should remind them about their age and their situation – for instance, that their husband had died. However, with time, we saw that bringing the residents back to reality is perhaps not always the best strategy, because every time you remind them that their spouse has passed away, they experience the sorrow again. And again. (. . .) So now, it's more like when they ask about their husband, we will distract them a little, talk about other things, perhaps ask them when they got married, or when their first child was born. . .

This distraction approach stands in sharp contrast to the "bringing back to reality" approach. The staff members who explained that they used the bringing back to reality approach explained how they, as sensitively and quickly as possible, would try to draw the attention of the resident back to the here and now. The staff using the back-to-reality approach in the case of Anna explained that, when she started to get upset, they would walk her gently back to her room to look at pictures in her family album, talk about her kind son, or gently remind her that her husband unfortunately had passed away, or they would talk about her former professional life, hobbies, or food preferences. A list with key information, which was easily available for all members of staff to access, read, and memorize, was made about each of the residents, for this purpose of bringing them back to reality. Another care worker specified this strategy in the following way:

> I answer that she is here because she has become forgetful, and I explain that "all our residents are forgetful, that's why you are here. However, please let me accompany you to your room so that we can take a look in your album. We always find some answers there."

The participant explained that this strategy always worked for her but added that she always tried to react quite quickly to answer Anna's questions and meet her feelings before she started to act out. A similar opinion was shared by another care worker, who said that residents needed and deserved to be met with respect, empathy and honesty and therefore "deserved to be brought back to reality." Talking about Anna specifically, she said:

> She [Anna] has not lost her feelings, so we need to show empathy. She is clever at reading our body language, so, when

she talks to us, we need to engage straight away and try to answer as well as we can. . .

Several staff members agreed with the idea that it was pivotal to be attentive to Anna as soon as possible when she started to ask questions. The aim was to curb the situation before it went out of control, because this situation would stress out the entire ward, including other residents and staff members.

The importance of knowing the residents. The back-to-reality approach required detailed knowledge of the residents and their background. A care worker explained:

> I'm lucky because I work here 80% and, therefore, I know the residents well. . . Eventually [with experience] you know the resident's reactions, and you become a master at reading signals, which makes it safer for me to work with them [residents that may be aggressive].

Staff members claimed that they sometimes felt that they were the "walking memory" of the residents. This was particularly the case for those working full-time or almost full-time, as was the case for the care worker who came to "rescue" the tense situation described above by reminding Anna that she was in the nursing home because her husband had died and her house had been sold, and thereafter started talking about Anna's son, before guiding her gently out and into the garden.

Christopher's Story

Christopher is a man in his early 70s who has been living in the nursing home for almost 1 year. He has dementia and a complex somatic health situation. He hardly speaks, but he repeats some sounds, soft or loud, which give the staff clues about how he is feeling. He is constantly wandering around, night and day, and he very seldom sleeps or rests much. On many occasions, he has been aggressive toward staff and other residents.

The situation that will be described in the following excerpt occurred in his room. Christopher was angry, and the researcher, who was slightly nervous while keeping her distance in the corridor, heard that he was kicking the walls and screaming out loud. Some residents seated nearby collectively withdrew from the area when they sensed Christopher's anger building up. Two experienced care workers from another ward were called upon to help Christopher calm down. One of the care workers who arrived, the researcher already knew, was from the same village as Christopher. This care worker knocked on the open door, waited in the doorway, greeted Christopher with a smile, and asked if he recognized her. Christopher did not answer and kept kicking the walls. The nurse remained in the doorway and calmly waited. After a while, she said hello again and waved her hand to him. Christopher looked at her. She called his name again and asked how he was doing.

He did not answer, but the researcher, who had approached the doorway, saw that Christopher was now looking in the direction of the doorway.

The care worker smiled at Christopher again and said something funny that she knew he liked to hear. Christopher calmed down and eventually smiled back. The care worker took a quick look at her colleague and nodded as a sign to indicate "Now you can enter." Christopher followed the two care workers to the bathroom. The researcher observed from the doorway how the two care workers collaborated in such a smooth way: one of them doing the talking, the other one doing the practical care work, washing him, putting on cream, shaving him, brushing his teeth, and getting him dressed. Christopher was relaxed. The care worker who did the talking sometimes imitated the sounds that Christopher made, to confirm that she heard what he was saying. When the care situation was finished, one of the care workers looked at Christopher and exclaimed: "Now Christopher [admiring him], well, you look handsome!" She pointed at him in the mirror. The care worker continued: "And now, Christopher, we who come from [name of their village] should go and have a nice cup of coffee and a biscuit together." She took his hand, and he followed her, calm and happy, heading for the kitchen.

Later that day, the researcher was told by some staff members what had triggered this incident: Early that same morning, a temporary, unskilled care worker had woken Christopher up from one of his rare and peaceful rests! The researcher therefore talked with the temporary care worker in question, who explained that she had done so because "showering Christopher" was on her to-do list that morning. It had all started quite well, but, as she undressed Christopher to prepare him for the shower, he had suddenly become angry and swung his arm toward her. He hit her really hard! Scared, the care worker had run out of the room to protect herself, and the situation had escalated until the two experienced care workers described above arrived. Obviously, neither the shift leader nor anyone else on the staff had warned the temporary care worker that Christopher was a resident who should never be woken up, even if showering him was on the to-do list, because that could upset him terribly. However, the researcher overheard several staff members, who, rather than taking collective responsibility for this incident, blamed the temporary care worker for having done a "mistake."

The importance of understanding how to prioritize. When the researcher talked with the manager in the nursing home about the incident with Christopher described above, the manager said that she was happy to have some "cornerstone colleagues" that could come to the rescue when other staff members could not cope with Christopher. The manager added that what had happened that particular morning did not come as a surprise, because, for some of the temporary care workers, making good decisions about prioritizing activities on their to-do list was hard. The manager said:

It's about understanding what comes first. Many of the care workers with immigrant backgrounds who come here to work are very dutiful, so they might organize that shower without even considering whether to do it later in the day. (. . .) In that sense, they are perhaps more dutiful in relation to the scheduled tasks, and they evaluate to a much lesser degree whether it's *wise* to shower a resident or not.

From this quotation, we see that the manager was concerned that temporary workers, who on this ward often happened to be women with an immigrant background, sometimes were more dedicated to carrying out the tasks assigned to them rather than being attuned to the residents and their needs. However, what is more striking is that the manager did not say anything about the fact that no one on the staff had the responsibility for informing the temporary care worker that this particular resident should not be woken in the morning if he slept, due to insomnia and a tendency to engage in challenging behaviors if woken. If the temporary unskilled care worker did not know Christopher particularly well, and if she did not receive the information she needed from the shift leader, how could she possibly be expected to understand "what comes first"?

The importance of caring with connection and concern. The care situation around Christopher was puzzling. Among the staff, he was known as "the most demanding resident" in the nursing home. The manager explained that she was careful to ensure that there was always at least one "cornerstone colleague" (often a registered nurse) around him. However, when it came to the task of cutting Christopher's fingernails, the manager proudly explained that it was an unskilled care worker in her early 20s, originally from Asia, who managed this task the best. It turned out that not only Christopher but even other residents preferred this particular care worker for certain personal care tasks. One of the "cornerstone colleagues" said the following about her young colleague:

> . . .She does not speak Norwegian, I would say. But, she has such a generous personality and warmth that makes everybody so happy. . . She is just so comfortable to be around, and the residents, they just love her! Of course. . . Well. . . I mean. . . You have to learn the language to work here, eventually, but the language will come as you go along. . . Our residents feel they can trust and rely on staff who are calm and comfortable to be around.

We see that, despite the lack of both formal competence and proficiency in the Norwegian language, and despite working part-time, this unskilled worker was preferred by several of the residents and regarded as a trusted employee by her more experienced colleagues. Several participants explained that good care has something to do with "the approach to the residents," such as how you greet them, talk to them, and show respect. The significance of calm body language, signaling good intentions toward residents, was also emphasized for

succeeding in assisting residents with tasks such as dressing and personal hygiene.

The importance of sharing success stories. To motivate each other to increase the quality of care on the ward, regular staff meetings were held. Therefore, the staff members gathered every morning at a set time to give each other brief updates on the residents' health and care situation, so that all staff could share knowledge. In these meetings, the manager encouraged staff members to share success stories with the rest of the team. In her interview with the researcher, she explicated:

> We should tell the others how we do things when we succeed! (. . .) Some staff can shower a certain resident while others can't manage. . . (. . .) Often, it is one of my employees with a minority background who has made it happen, but if they had not been told to share, they probably would not do so. . .

Sharing success stories had a double effect: first, the success of staff members in providing care with connection and concern for residents who often resisted was recognized; second, staff provided each other with inspiration and tools to better handle similar situations in the future.

Discussion and Conclusion

Challenging behavior among nursing home residents may be viewed as a cry for help, a desire for attention, or an expression of bodily pain. Challenging behavior, moreover, may in some situations be the only way a resident is able to make contact with others (Krishnamoorthy & Anderson, 2011; Selnes, 2003). Every human being has an underlying urge to feel community and belonging. Challenging behaviors may be a sign of not being understood, signifying something like "See me!" "Why don't you understand what I want?" or "Help me!" It can also be a way of gaining attention and achieving a reaction from the surroundings, which may help counteract a feeling of loneliness and inner emptiness (Selnes, 2003, p. 18, see also Walsh et al., 2021).

This study analyzed how concrete situations of challenging behavior unfolded and how members of staff and management made sense of these incidents. We found that challenging behavior occurred both in personal care situations and communication situations in common rooms. Some of the situations of challenging behaviors analyzed in this study were rooted in how care staff responded or sometimes *failed to respond* to residents' needs. This finding is in line with previous studies that found that negative interactions, such as ignoring the resident, treating the resident with lack of knowledge, or with restraint or fear, as was found in this study, or making demands that exceed cognitive and functional capacity, could increase challenging behaviors (Stein-Parbury et al., 2012).

In line with previous research (Erkutlu, 2012; Kim & Park, 2017; Todd & Watts, 2005), moreover, this study highlights

that organizational factors, such as staffing practice, organizational culture, role definition, support mechanisms, knowledge sharing, and staff awareness of when to follow procedures and when to use discretion, are significant factors in increasing competence among staff and thus reducing the occurrence of challenging behaviors. The nursing home management in our study talked about the importance of continued learning by letting members of staff share success stories of handling difficult care situations. Even if other members of staff did not necessarily succeed in using the same approach as someone else, and although we observed a tendency of *not* taking collective responsibility for incidents of challenging behaviors that happened on the ward, the sharing of success stories may be assumed to gradually foster an atmosphere of collaboration and mutual support.

What seemed to curb challenging behavior in our study was primarily when care workers were able to "tune in" and respond to residents' needs with connection and concern and, as a result, make wise, timely, and sensitive use of key knowledge about residents in line with the principles of PCC (Brooker, 2003; Kitwood & Bredin, 1992; McCormack & McCane, 2017). This seemed to happen on and off in the nursing home under scrutiny, which may be a sign that the organizational culture may lie somewhere in the middle of the continuum between "rigid" and "proficient" (Glisson et al., 2008). The importance of "tuning in" to the situated and changing care needs of the residents resonates with the work of Kittay (2011), who found that good care requires staff who are attentive, caring, and competent in their interaction with patients. This was also found in a study by Todorova et al. (2016) who argued that care should be provided within a committed, vigilant, and meaningful relationship of caregivers and care recipients. Organizational cultures that support the residents' needs for love, attachment, comfort, identity, occupation, and inclusion enhance self-worth and the feeling of being valued and may reduce the incidence of disruptive behaviors (Brooker, 2003; Slater, 2006). Thus, within a proficient organizational culture, care workers may be more attentive to each individual resident, to foster the cooperation and involvement of the residents (Adams & Gardiner, 2005; Mitchell & Agnelli, 2015). Similarly, and in line with the principles of PCC, our empirical data showed that the possession and timely use of knowledge about the resident's life story and preferences was crucial to successfully handling and calming down escalating situations. Thus, care workers who knew the residents and their backgrounds well could more promptly answer questions asked by the residents about their former personal life. In the nursing home in this study, personal information about each resident was easily available to all staff working on each ward. However, temporary staff in small part-time positions were not familiar with this information. Due to their irregular and limited shifts on the ward, they were also not expected by management to become acquainted with this information. This lack of familiarity explains how challenging situations may arise, as a result of some staff not being fully informed about how to approach and communicate with vulnerable residents.

Thus, there is a need to foster a proficient and flexible organizational culture and a staffing practice in which care workers are empowered to use their discretion, and to emphasize psychosocial aspects of their daily work. While, in some studies, using discretion and making good decisions seem to be related to staff's educational level (Unruh et al., 2007), other studies indicate that a "highly competent care staff" depends on whether or not the staff members have a "genuine interest" in the residents and, thus, whether or not they have the ability to meet the vulnerabilities of nursing home residents in a calm, respectful, and attentive manner (Munkejord & Tingvold, 2019). However, whether or not staff members are enabled to show a genuine interest in the residents and to meet them in a calm, respectful, and attentive manner depends on the organizational culture of the nursing home (Cassie, 2012; Munkejord, 2019; Tingvold & Munkejord, 2021).

The occurrence of challenging behavior among residents in this study was sometimes interpreted by the core staff, and even by the manager herself, as the result of the wrong-doings of "immigrant staff," who were assumed to "lack the necessary language skills" or "lack the ability to use discretion." However, our analysis indicates that the challenging behavior identified in this study should not be interpreted as a matter of linguistic deficiency or cultural difference. Additionally, it should not be interpreted as a matter of "difficult" or "aggressive" residents. Rather, the challenging behavior in the nursing home under scrutiny seemed to be at least partially an unintended consequence of lack of awareness about the importance of knowing key information about the residents in the ward in order to be able to respond to their requests, and thus to care for them with connection and concern, to use Kittay's (2011) terms.

To conclude, in line with a PCC approach (e.g., Brooker, 2003; Kitwood & Bredin, 1992; McCormack & McCane, 2017), our findings show that the following dimensions seem to curb challenging behaviors among nursing home residents: (a) increasing staff knowledge of the residents, (b) enabling staff to respond promptly and sensitively to residents' feelings, and (c) building a solid staff culture, in which all members are involved in "continued learning" by sharing successful experiences and taking collective responsibility for the well-being of residents. In order to counter-act the high use of sedatives and other drugs in nursing homes, more research about non-pharmacological interventions to reduce challenging behaviors among nursing home residents with dementia is needed.

ORCID iD

Mai Camilla Munkejord https://orcid.org/0000-0002-5700-7639

References

Adams, T., & Gardiner, P. (2005). Communication and interaction within dementia care triads: Developing a theory for relationship-centred care. *Dementia*, *4*(2), 185–205. https://doi.org/10.1177/1471301205051092

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*, *11*(4), 589–597. https://doi.org/10.1080/2159676X.2019.1628806

Brooker, D. (2003). What is person-centred care in dementia? *Reviews in Clinical Gerontology*, *13*(3), 215–222. https://doi.org/10.1017/S095925980400108X

Cassie, K. M. (2012). A multilevel analysis of aggressive behaviors among nursing home residents. *Journal of Gerontological Social Work*, *55*(8), 708–720. https://doi.org/10.1080/01634372.2012.703764

Erkutlu, H. (2012). The impact of organizational culture on the relationship between shared leadership and team proactivity. *Team Performance Management*, *18*(1/2), 102–119. https://doi.org/10.1108/13527591211207734

Gjerberg, E., Lillemoen, L., Pedersen, R., & Førde, R. (2015). Coercion in nursing homes: Perspectives of patients and relatives. *Nursing Ethics*, *23*(3), 253–264. https://doi.org/10.1177/0969733014564907

Glisson, C., Landsverk, J., Schoenwald, S., Kelleher, K., Hoagwood, K. E., Mayberg, S., & Green, P. (2008). Assessing the organizational social context (OSC) of mental health services: Implications for research and practice. *Administration and Policy on Mental Health*, *35*(1–2), 98–113. https://doi.org/10.1007/s10488-007-0148-5

Kales, H. C., Gitlin, L. N., & Lyketsos, C. G. (2015). Assessment and management of behavioral and psychological symptoms of dementia. *BMJ*, *350*, h369. https://doi.org/10.1136/bmj.h369

Kim, S. K., & Park, M. (2017). Effectiveness of person-centered care on people with dementia: A systematic review and meta-analysis. *Clinical Interventions in Aging*, *12*, 381–397.

Kittay, E. F. (2011). The ethics of care, dependence and disability. *Ratio Juris*, *24*(1), 49–58. http://evafederkittay.com/wp-content/uploads/2015/01/The-ethics-of-care.pdf

Kitwood, T., & Bredin, K. (1992). Towards a theory of dementia care: Personhood and well-being. *Ageing & Society*, *12*, 269–287. https://doi.org/10.1017/s0144686x0000502x

Krishnamoorthy, A., & Anderson, D. (2011). Managing challenging behaviour in older adults with dementia. *Progress in Neurology and Psychiatry*, *15*(3), 20–26. https://doi.org/10.1002/pnp.199

Legere, L. E., McNeill, S., Schindel Martin, L., Acorn, M., & An, D. (2018). Nonpharmacological approaches for behavioural and psychological symptoms of dementia in older adults: A systematic review of reviews. *Journal of Clinical Nursing*, *27*(7–8), e1360–e1376. https://doi.org/10.1111/jocn.14007

McCormack, B. (2004). Person-centredness in gerontological nursing: An overview of the literature. *Journal of Clinical Nursing*, *13*(3), 31–38. https://doi.org/10.1111/j.1365-2702.2004.00924.x

McCormack, B., & McCane, T. (Eds.). (2017). *Person-centred practice in nursing and health care. theory and practice*. Wiley Blackwell.

Mitchell, G., & Agnelli, J. (2015). Person-centred care for people with dementia: Kitwood reconsidered. *Nursing Standard*, *30*(7), 46–50. https://doi.org/10.7748/ns.30.7.46.s47

Morgan, D. G., Crossley, M. F., Stewart, N. J., D'Arcy, C., Forbes, D. A., Normand, S. A., & Cammer, A. L. (2008). Taking the hit: Focusing on caregiver "error" masks organizational-level risk factors for nursing aide assault. *Qualitative Health Research*, *18*(3), 334–346. https://doi.org/10.1177/1049732307313754

Munkejord, M. C. (2019). Challenging the ethnic pyramid: Golden rules and organisational measures towards a more inclusive work environment. *Journal of Nursing Management*, *27*(7), 1522–1529. https://doi.org/10.1111/jonm.12838

Munkejord, M. C., & Tingvold, L. (2019). Staff perceptions of competence in a multicultural nursing home in Norway. *Social Science and Medicine*, *232*(C), 230–237. https://doi.org/10.1016/j.socscimed.2019.04.023

Øye, C., Jacobsen, F. F., & Mekki, T. E. (2017). Do organisational constraints explain the use of restraint? A comparative ethnographic study from three nursing homes in Norway. *Journal of Clinical Nursing*, *26*(13–14), 1906–1916. https://doi.org/10.1111/jocn.13504

Selnes, K. (2003). *Toleranse og ferdighet: etablering og drift av en forsterket skjermet enhet for personer med demens*. Nasjonalt kompetansesenter for aldersdemens. [Tolerance and competence: Establishing and running sheltered homes for people with dementia]. National Competence Centre for Dementia.

Slater, L. (2006). Person-centredness: A concept analysis. *Contemporary Nurse*, *23*(1), 135–144. https://doi.org/10.5172/conu.2006.23.1.135

Spradley, J. P. (1980). *Participant observation*. Harcourt Brace College Publishers.

Stein-Parbury, J., Chenoweth, L., Jeon, Y. H., Brodaty, H., Haas, M., & Norman, R. (2012). Implementing person-centered care in residential dementia care. *Clinical Gerontologist*, *35*(5), 404–424. https://doi.org/10.1080/07317115.2012.702654

Stokes, G. (2017). *Challenging behaviour in dementia: A person-centred approach*. Taylor & Francis.

Tingvold, L., & Fagertun, A. (2020). Between privileged and oppressed? Immigrant labor trajectories in Norwegian long-term care. *Sustainability*, *12*(11), 1–17. https://www.mdpi.com/2071-1050/12/11/4777

Tingvold, L., & Munkejord, M. C. (2021). Shared goals, communication and mutual respect in multicultural staff teams: A relational coordination perspective. *Nursing Open*, *8*(2), 957–965. https://doi.org/10.1002/nop2.704

Todd, S. J., & Watts, S. C. (2005). Staff responses to challenging behaviour shown by people with dementia: An application of an attributional-emotional model of helping behaviour. *Aging & Mental Health*, *9*(1), 71–81. https://doi.org/10.1080/136078 60412331310254

Todorova, I., Turner, H., Castaneda-Sceppa, C., Young, D., & Bonner, A. (2016). "I Do It With Love": Engagement in caring for people with dementia. *Global Qualitative Nursing Research*, *3*, 2333393616668634. https://doi.org/10.1177/233339361666 8634

Unruh, L., Joseph, L., & Strickland, M. (2007). Nurse absenteeism and workload: Negative effect on restraint use, incident reports and mortality. *Journal of Advanced Nursing*, *60*(6), 673–681. https://doi.org/10.1111/j.1365-2648.2007 .04459.x

Voyer, P., Verreault, R., Azizah, G. M., Desrosiers, J., Champoux, N., & Bédard, A. (2005). Prevalence of physical and verbal aggressive behaviours and associated factors among older adults in long-term care facilities. *BMC Geriatrics*, *5*(1), 13. https://doi.org/10.1186/1471-2318-5-13

Walsh, B., Dahlke, S., O'Rourke, H., & Hunter, K. F. (2021). Nurses' decision-making related to administering as needed psychotropic medication to persons with dementia: An empty systematic review. *International Journal of Older People Nursing*, *16*(1), e12350. https://doi.org/10.1111/opn.12350

Author Biographies

Mai Camilla Munkejord, MSc, PhD is a postdoctoral researcher at Centre for Care Research, Region West, at Western Norway University of Applied Sciences, campus Bergen, Norway.

Laila Tingvold, MSc, PhD is a senior researcher at Centre for Care Research, Region Middle, at Norwegian University of Science and Technology, campus Gjøvik, Norway.