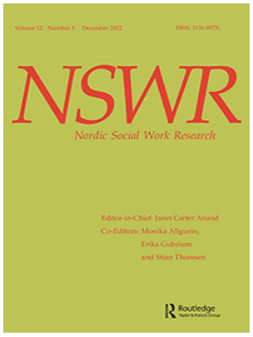

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Swedish eldercare within home care services at night-time: perceptions and expressions of 'good care' from the perspective of care workers and care unit managers

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ABSTRACT

This article aims to explore and analyse how good and dignified care is perceived and expressed at night-time within elder home care services, in which night-time care represents a knowledge gap. Dignity has become a legislated value in Swedish eldercare, aiming to increase the quality of care and to clarify the ethical values of everyday care practice. The data presented here come from a qualitative case study with in-depth interviews with six care unit managers and 14 care workers in four municipalities. The analysis of the interviewees' perceptions and expressions of good care were informed by Nodding's concepts: responsiveness, receptivity, and relatedness. The results showed that there was a relative unawareness of the new goals of the dignity policy and there was no specific guidance regarding dignity during night-time care. The care unit managers' perspective was mainly administrative and related to the policy level and the staff's ability to care. The care workers' view of good and dignified care included aspects of ideal characteristics and user-centredness with a focus on older people's individual needs. However, good care was conditioned by time. The dignity policy, as described in national documents, was perceived by the interviewees as vague and with unreachable goals constructed on the structural level. In social care practice, however, expressions of good and dignified care were already found in care ethics, regardless of the dignity policy. By bringing relationality to the dignity discourse on the structural policy level, recognition of care may be emphasized.

KEYWORDS

Night-Time elder home care services; the Swedish dignity policy; good and dignified care; care unit managers; care workers

Introduction

This article focuses on the social practices of Swedish home care services at night-time, a research field that is largely unexplored. Home care services in ordinary housing are the most common type of social care support for older people, and in 2018 approximately 11% of all people in Sweden over 65 years of age (220,131 individuals) had home help support, of which 56,479 individuals had 50 hours of care a month or more around the clock (sdb.socialstyrelsen.se). There are, however, no official statistics on night-time care, although one might assume that many or most of those having more than 50 hours per month will have at least some night-time care services. Sweden is quite unique in having mobile teams of community care workers supporting older people in their homes at night, in comparison with other European countries like Italy and Spain that have live-in care

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arrangements, with care often provided by illegal migrant workers (cf. Di Rosa et al. 2012; Österle and Bauer 2016).

In times of retrenchment and economic austerity, the distribution of care for vulnerable older people is facing new challenges (Andersson and Kvist 2015). In policy making, a renewed interest in dignity and individualized social care has been highlighted within eldercare on the national and local levels in Sweden and in several other countries, and professional guidelines emphasize user or person-centred care in order to promote self-determination and control for the care users (Andersson 2018; Lloyd and Sullivan 2018). There is often a gap between ideals and the realities of practice that challenge professional workers and raise ethical dilemmas in care practice by competing values. One such dilemma is to help the older service users to understand and assert their rights to support, while keeping a budget. However, not only due to the economic context, marketization trends tend to favour organizational understanding rather than the service users' needs (Lloyd and Sullivan 2018). In other words, care systems in diverse societies seem to create inequalities between older people, especially for disadvantaged groups (cf. Andersson and Johansson 2019).

It is important to problematize care in relation to the structural changes within social eldercare that we see today in Sweden and in many other western societies, including austerity and marketization trends (cf. Meagher and Szebehely 2013; Lloyd and Sullivan 2018), where time and continuity are often in short supply in eldercare but which are also prerequisites for care. Key concepts like choice, participation, user-centredness, influence, and quality of care have been highlighted in the policy and practice of public eldercare, which more or less depend on older people being capable of being active consumers of care and having awareness of their rights to care regardless of individual circumstances and vulnerability (Andersson and Kvist 2015).

Dignity has become a central value in Swedish eldercare since January 2011, when a policy change in the Social Services Act was legislated for older people's rights to dignified care and wellbeing (SFS 2010: 427 law change of SFS 2001: 453, 5 chap. § 4). The purpose of the new introduction of ethics and values was to increase the quality of social care and to clarify the human perceptions and values that should guide the daily activities of eldercare (Prop. 2009/10:116 ; SOU 2008: 51). However, there is little knowledge about how the national policy goals of dignity and wellbeing for older people are implemented in actual care work practices on a local level (Andersson 2018), and there are reasons to believe that there is a gap between policy and practice.

Our empirical material derives from a research project[1] aiming to explore and analyse how Swedish home care services are organized, performed, and experienced at night-time. This article explores one of the project's research questions: how are older people's dignity and safety secured at night in response to the new legislation and how do night-time home care services deal with the new policy goals of dignity. Because we know very little about how dignity goals are met, this article aims to explore and analyse how dignified care is perceived and expressed, or more broadly how 'good care' is expressed and perceived at night from the perspectives of care workers, and care unit managers in night-time home care services.

Context of Swedish eldercare

It is the local authorities' responsibility to provide eldercare in the municipality. Care services vary according to need and are provided to older people and those people under 65 with disability who do not qualify for LSS – 'the special disability rights legislation' (SFS 1993:387) – or if they cannot find personal assistants. The Swedish welfare system and eldercare can still be regarded as generous and well established with several public opportunities available for assistance and care.

Since the early 1990s, several changes such as rationalizations and organizational changes have been made to reduce the cost of elderly care, and public elderly care has headed towards marketization principals of care, emphasizing ideas taken from trade and industry, turning public elderly care somewhat into a market (cf. Szebehely 2011; Meagher and Szebehely 2013). For several

decades, resources for eldercare in relation to the ageing population have decreased. Spending between 2000 and 2009 also decreased 6% in absolute terms (Szebehely and Trydegård 2012). Furthermore, research indicates that local variation between municipalities' provision of eldercare has increased, which can be seen as a threat to universal care (Trydegård and Thorslund 2000; Trydegård and Thorslund 2010; Szebehely and Trydegård 2012).

The new national wording in the Social Services Act: '[The] care of older people should focus on giving older people a dignified life and feeling of wellbeing' (SFS 2010: 427 law change of SFS 2001: 453 , Chap. 5, § 4) is vague and provides no explicit guidance for Sweden's 290 municipalities and may thus be interpreted differently between them. This is mainly because the Act is a goal-oriented frame law and because the Swedish system of national governance makes each municipality responsible for community eldercare and services (Prop. 2009/10:116 ; Szebehely and Trydegård 2012, 2018).

The Swedish dignity policy and local dignity guarantees

On the national level, *dignity* has been defined under four guiding themes: high-quality care; respect for privacy and integrity; self-determination, participation and influence, and individualization; and good responsiveness (*in Swedish: gott bemötande)* of care. *Wellbeing* has been defined as safety and meaningfulness (SOSFS 2012:3). The policy of dignity implicitly rests on the assumption of undignified eldercare and that eldercare staff cannot give appropriate and dignified care (Andersson 2018).

The national values regarding dignity in social eldercare have been reformulated as 'local dignity guarantees'. These guarantees were mandated to be formulated with a solid emphasis on older people's rights to have influence in the performed social care, and they concerned promises made by the municipalities (usually found on their websites), such as that older people should have a contact person and an individual implementation plan issued within a certain period of time (NBHW 2015).

These guiding principles and guarantees need to be critically discussed in order to ascertain whether these become mere words in documents rather than focusing on ethically important values about social care for vulnerable people and how these are put into practice (Nordenfelt 2009; Pols 2013). Furthermore, the conditions for implementing dignity in care practice have not been made explicit in the document goals (SOSFS 2012:3). However, the goals of all eldercare should be implicitly designed in dignified ways. Nevertheless, one might raise the question of whether it is even possible to legislate for dignity and how this might be accomplished in actual care practice.

Research on eldercare at night-time – a knowledge gap

Research on eldercare at night-time is overall a neglected field, and we know little about formal night-time eldercare in ordinary housing, and this applies both nationally and internationally. Private care arrangements with live-in or live-out migrant care workers have become a primary alternative in Mediterranean countries, often employing illegal workers to meet the demands of the ageing population for increased long-term care in their homes (Di Rosa et al. 2012; Österle and Bauer 2016). In Austria, a legal framework for '24-hour care' was introduced in 2007 and 2008, allowing migrant care workers to be employed by care users, their families, or social service providers, but predominantly to work through self-employment (Österle and Bauer 2012, 2016). However, this Austrian form of 24-hour care does not come close to the night-time home care services in Sweden.

The few available studies of night-time care have mainly been within residential care, with a focus on nursing practice (e.g. Gustafsson, Fagerberg, and Asp 2010; Nilsson, Campbell, and Andersson 2008; Powell 2013) or residents' sleeping disorders (Kerr, Wilkinson, and Cunningham 2008). Medical research has also focused on falls and other health-related conditions at night

(Jensen et al. 2002), such as how dementia affects residents' quality of sleep in residential care homes (Ellmers et al. 2013; Martin and Bartlett 2007). Research on night-time care from nursing perspectives reveals poor working conditions, such as a lack of leadership and expert support and fewer opportunities for professional development and education compared to daytime work, which gives low status and recognition to night-time work (Gustafsson, Fagerberg, and Asp 2010; Nilsson, Campbell, and Andersson 2008; Powell 2013).

A Swedish research study (Andersson and Kalman 2017) and our project's survey (Andersson and Sjölund Forthcoming) reveal that scheduled care services include intimate care such as help using the toilet, turning over in bed, and changing diapers. Other scheduled care services are of more practical character such as safety visits to see that the care recipients are alright, and/or webcam monitoring and help with medication and food. Many of the older people also have safety alarms in their homes in case they fall or need other help during the night, resulting in more unscheduled visits and meaning that care workers have to be flexible and prepared to respond immediately. The night-time working staff usually has ten-hour shifts starting in the evening around 9 p.m. and finishing in the morning around 7 a.m. Most municipalities organize night-time care in mobile patrols of two care workers, usually trained auxiliary nurses. Some municipalities also have single working patrols at nights (Andersson and Kalman 2017; Authors). All in all, in comparison with daytime care work, the care work at night is characterized by many short visits, a lot of car driving, and unpredictability because there are many emergency alarms to handle at night-time.

Relational aspects of care – theoretical framework

The concept of dignity is abstract, and there is no consensus on how to define dignity within the sector of eldercare. However, there is an implicit agreement that all health and social care should rest on ethical values of dignity (Nordenfelt 2009). Most ethicists describe dignity as a basic value or set of values that all human beings possess and that should be respected by everyone, including the individuals themselves (Ibid.). Dignity is a dynamic concept and includes subjective experiences and shared human values. Within health and social care sectors, it is the professionals who have a central role in giving and upholding dignified care to recipients (Haddock 1996; Lloyd et al. 2014; Pols 2013).

Theories of dignity are often focused on the individual instead of on the relational connectivity of care ethics (Miller 2017). We therefore approach good and dignified care as relational because it emerges in concrete care practice in a social context through relationships with others (Pols, Pasveer, and Willems 2018). Early Scandinavian care research has been influenced by the care ethicist Noddings (1984) feminist approach to care where she argued for the relationship as the foundation to ethics of care. Central for caring is relatedness, as a mutual relation between the assistant and assisted; receptivity to understand and interpret the care receiver's needs; and responsiveness by showing respect and being sensitive to the care receiver's needs (ibid.).

Care research has above all highlighted the relationship between caregiver and care receiver as central for care work within eldercare, which always forms an asymmetric relationship (cf. Eliasson 1992; Szebehely 1995; Wærness 1984). Besides the focus on power relations and organizational perspectives of social care research, care work has primarily been described as an individual responsibility of the care worker for the care recipient. The personal qualities of the care worker and the ability to establish genuine and mutual care relationships have been regarded as important characteristics and skills that predominantly are possessed by women (cf. Szebehely 1995; Wærness 1984). Care has also been contextualized politically in order to avoid individualization of care as personal characteristics possessed by (female) caregivers (cf. Dahl 2010; Tronto 1994).

In this article, we attempt to understand and analyse good care as relational by taking a perspective towards care ethics that draws on the philosopher Sara Clark Miller's (2017) three themes for bringing care ethics into the dignity discourse. The first involves an understanding of the

ways in which care can be dignifying with a focus on the attitude of care. The second focuses on action and how the ability to care might function as a distinguishing moral power. The third sees dignity as fundamentally relational, in contrast to dignity as an individual rationale. Our point here is to discuss how the *dignity policy* comes into play and how our interviewees perceive good care at night-time eldercare.

Material and methods

This article reports from the project's qualitative case study in order to provide an in-depth understanding of night-time care, particularly in relation to our interviewees' perceptions and interpretations of good care (cf. Alvesson and Sköldberg 2000; Merriam 2009). The project also includes a survey (presented elsewhere, Authors) with care unit managers in several different municipalities to contextualize goals of dignity policy and safety at night more broadly and structurally.

The case study was conducted during 2017 in two large and two small municipalities with regional variation. The four care units at night-time were run by municipal providers. In-depth interviews were conducted with six care unit managers, all Swedish females between 30 and 60 years of age, of whom one had recently left her position. In one of the larger municipalities there were two managers and they were interviewed together. They all had an academic background, two in social work, three in social care and one in leadership and management and their experiences of management varied between two years and 18 years. The 14 care workers were between 17 and 60 years of age, and all were females except for one younger male and all were Swedish except for one from Finland. They were all trained auxiliary nurses except for one, the youngest, who was in training to become one. The staff in the smaller municipalities were older in comparison to the staff in the larger municipalities.

The care unit managers were contacted by email with a written presentation of the project, and after their consent to participate we made appointments for interviews that took place at their office during working hours. The interviewed care workers were selected on a voluntary basis, and after giving their consent, the interviews took place mainly during their night shift, and sometimes after, but on one occasion during their free time. A similar interview guide was used with the two groups containing questions structured by four themes: working conditions at night-time; dilemmas; older peoples' safety; and perceptions of good care at night. All the interviews were recorded with the interviewees' consent and lasted between 20 and 90 minutes, with an average length of 40 minutes, and were then transcribed verbatim.

Ethical considerations

Ethical approval for the project was given by the Regional Ethical Review Board in Umeå, Sweden (Reg. No. 2016/55-31) in accordance with the Act concerning Ethical Review of Research Involving Humans (SFS 2003:460). All interview data have been anonymized and placed in safe web storage with locked passwords according to the university's ethical standards. The quotes in this article are identified by two numbers representing the municipality and person as well as the interviewed group in order to maintain the anonymity of the informants.

All the interviews rested on the interviewee's consent. Because all subjects were related to the staff's work and situation, both the staff and the care unit manager group were interested in talking to us.

Analysis

The analysis focused on the interview guide's fourth theme, that of perceptions of good care at night, which included questions on dignified care. By putting an analytical focus on expressions of good care, we especially account for the experiences of giving and providing social care, and what

care workers and care unit managers found to be important at night-time. A thematic content analysis was performed to show how good care was perceived across the two groups (Hsieh and Shannon 2005). The identified themes were derived from our readings of the interviews in the case study, with a particular focus on the direct questions of what constitutes dignified care, but also on more latent expressions of 'good care', which we related to perceptions of dignity (cf. Lloyd et al. 2014). Each group of interviews was analysed separately to identify common and diverse themes of expressions of dignified care. Thereafter, by letting the analysis of the two perspectives be informed by Nodding's concepts: responsiveness; receptivity and relatedness, contrasts and similarities were interpreted in contextual and holistic ways but in their specific situation (cf. Andersson and Kalman 2012; Stake 2006).

In the second step of the analysis our results were compared with Miller's (2017) discussions of dignity as being fundamentally relational. In three themes she considers the concept of care and dignity together. Briefly, the first theme, 'care as dignifying', refers to the manner in which we meet others' needs. The second theme, 'the moral power of care', puts care action in focus along with the capacity of caring. In the third theme, 'dignity as fundamentally relational', she discusses the significance of relationality for dignity.

Results of the case study – experiences and perceptions of good and dignified care at night

The analysis of the two groups – care unit managers and care workers, is presented separately because of their different positions'; the managers being responsible for staff matters, planning and provision of care at night, and the care workers being closest to the recipients, the providers of care in night-time home care services.

The interviews revealed both differences and similarities in relation to perceptions and experiences of good care within the two groups. One striking similarity was the relative unawareness of the Social Services Act's new goals of dignified care and wellbeing of older people. The two rural municipalities had no local dignity guarantees, but one of them had plans to implement them. The two urban municipalities had both implemented local dignity guarantees, although none of the interviewees in the four municipalities mentioned any guiding documents about dignity in relation to their management work or the provision of care at night. Due to their different roles in the organization however, their experiences differed.

The analysis is structured and presented under headings taken from Noddings's (1984) conceptualization of caring: responsiveness, receptivity and relatedness.

Care unit managers' responses to good and dignified care

Responsiveness; the dignity policy goals

A recurrent aspect of planning for good and dignified care according to the care unit managers was trying to keep continuity among the staff. One of them related how they planned for and placed the staff in the various night patrols: 'so that the care recipients know that there will be the same staff at night' (4:1 care unit manager). This was expressed in relation to increase responsiveness among the staff by becoming more familiar with the care recipients.

The two managers who were interviewed together related to the structural level of the municipality when arguing for the few goals of night-time care:

> There are no goals set up. So we are valued as nothing at night. There is no requirement for anything. No demands on implementation, no requirement for continuity, no plan. The night is excluded from that. We try to work with it anyway, but the hard thing I think is not being measured and not getting a good idea of the target. (2:1 care unit manager)

Even if this manager felt dejected and that care work at night was not valued by the municipality, it was still seen as important to continuously try to work with dignity and safety at night, other managers said that they needed more support to work with the dignity policy. As the care unit managers described, there are many challenges in providing care at night, and to be a manager meant that they started earlier than their official work time because they wanted to meet their staff in the morning before they finished their night shift.

The former care unit manager who had participated in education organized by the National Board of Health and Welfare was engaged in implementing and work with the dignity policy:

> I tried to constantly talk about the dignity goals … It's hard to take ten minutes here and there. You would have to work more constructively with it. So I wish I had more time. Because [the dignity policy] is an important foundation for responsiveness, that we help the users in a good way. In addition, those who have worked for a long time say 'yes, we are in a competitive organisation, if we do not meet the users in a good way they leave us' … I probably would have liked to work more on that [dignity] (2:3 care unit manager).

This manager was one of few that articulated responsiveness in relation to the organizational system that should increase care recipients' rights. However, there was no alternative to choose among different providers in the municipality at night-time.

Receptivity; Competence and personal suitability

To show respect for individual needs was not always self-evident to all the care workers, and some care recipients did complain, according to the former care unit manager: 'If I am lying in my bed, you do not just pull off the blanket; one of my users said: "I was exposed, I was not prepared"' (2:3 former care unit manager). These types of disrespectful and thoughtless actions were sometimes explained as care workers' personal unsuitability and inappropriate competence for that type of work. At the same time, as this manager said, it could also be referred to as lack of a caring attitude or responsiveness:

> Because you think that they should know how to, what is self-evident to me, how to be respectful towards the care recipients in their homes, it's apparently not the case for some of them.

In the role of being a manager for the staff, there were a lot of challenges with staff and one of the managers' checked the work at night-time:

> I went with a patrol with young people who were incredibly nice to the customers … now they were known customers so we knew what to do specifically, how to talk and so on. Like I said you give a little extra too, that you see other things than just the little thing to be done (4:1 care unit manager).

This quote reveals that although she felt that that the care workers were responsive, they could have done more, a little bit of extra for the care recipient. Another manager expressed herself in terms of always putting the care recipient in the centre for care:

> For me, personally, dignity is that you have influence and participation. That one may retain one's personal integrity. That those who come to my home understand that 'I'm not old and sick' for them to have a job. Without them actually being there for my sake, this is my home. It is important for dignified care. Also, you have to keep your times and routines. For example: if I haven't gone to bed at seven before – why would I start doing it? It is not our planning that will guide the individual needs. It is the individual who controls our planning. Who are we here for? The care recipient is in focus, which is important (1:1 care unit Manager).

This manager was critical towards the care workers' ability to be receptive towards the care recipients' needs and of not understanding their role as care providers. Even the organization of care interventions seemed to be the care workers responsibility.

Relatedness; summing up the care unit managers' perspective as mainly administrative

Not surprisingly, the care unit managers were occupied with planning and organizing the provision of care and to be a manager for the care staff. This included to be flexible with the working time in order to meet the staff after they left the night shift. A manager in one of the

rural municipalities who were in process of implementing local dignity guarantees expressed herself as following:

> We have dignity guarantees and the purpose of them is that they should 'top up' what the dignity policy says. We should do it even better than what the policy says we must. One guarantee is that all staff who come to your home should wear a name tag. The second is that an implementation plan should be made no later than three weeks after the interventions have started, and the third is that if you get a day-care services granted, you will be offered a home visit by the staff and that is, in addition to what the policy says (3:1 care unit manager).

Our analysis reveals that the managers' focus was on their care staff when referring to responsiveness and receptivity mainly in relation to the policy level and staff competence and suitability. The interviews did not trace any obvious talk around relatedness, the care relation per se, although one could argue for their concern for the relationship by their staff's competence and abilities to care.

Care workers' responses to good and dignified care

Responsiveness; ideal personal characteristics

The care workers said that they talked a lot about responsiveness towards the care recipients – 'Being thoughtful and aware that you are in someone else's home, you have to be humble and responsive' (1:4 care worker). Other care workers emphasized dignity at night as being quiet:

> Dignity is about being quiet and smooth, but to talk about *real* dignity, then they should have influence, 'how do you want to live and who do you want to come to help you', that is not possible at all (4:1 care worker).

She continued by arguing that dignity is a huge topic:

> Dignity is something that looks good on paper, but sometimes it is not possible to fulfil those values because the person should not live at home, it will not be dignified care.

This quote reveals an almost utopian view of providing a dignified manner of care because there is more to dignity than the relational aspects of care, like having decent living conditions.

Overall, the care workers emphasized values of respect, empathy, humanity, and humility towards the care recipients, which they found to be ideal characteristics for providing good and dignified care. However, the short visits and the unpredictability of the work were nightly challenges that the care workers emphasized as threats for acting as good caregivers. However, it was important to try one's best according to the care workers.

Good and dignified care was also expressed as striving to give something extra, to sit down for a while and to put the individual recipient in focus so that they felt important: 'We are striving to be the angels of the night' (2:3 care worker).

A common but striking argument for good care was to refer to time as being a precondition for dignity and dignified care. In fact, time was one of the most relevant factors for dignity at night, according to the care workers. However, adequate time was often missing in night-time care work, and this affected the quality of care according to the care workers.

> When we started to work at night, we talked a lot about being there for the recipients and comforting them; we went around and secured them at night. Now there is more bed and body work. We have care recipients who cannot move themselves, the work has become heavier (3:1, care worker).

This quote illustrates not only the dimensions of having less time for care than in earlier times, but also reveals care recipients' increased dependency, due to severe disability, which consequently means heavier work, both physically and emotionally, also at night (cf. Andersson 2008, 2013).

Receptivity; user-centred care

The care workers often highlighted individuality, in terms of placing the recipient's needs and wishes at the fore, even if it was challenging at night with many short visits in their homes. they should act as a professional, always placing the recipient's needs at the fore, regardless of the

recipient's behaviour. As one care worker said: 'To shift between the different care recipients, that is sometimes very challenging; we should know all of them and their needs' (1:1 care worker). Sometimes this could be very demanding and cause personal conflicts, but those who had worked longer seemed to handle this better. According to the care workers, learning about every recipient's needs and preferences was important for dignified care, although some of them were not able to communicate their wishes, for instance, in cases of dementia. This also included listening to and respecting recipients' individual needs and wishes.

Working at night-time meant managing many different needs and wishes, and some of the care workers thought that they could not live up to the goals of dignity at night. 'Dignity is about having self-determination, it was so important, we started an education, but it always flows out in the sand' (3:2 care worker). This quote reveals a common argument of the workers in relation to the goals of dignified care as something coming from 'above', from the management level, with no further plans or ambitions for how it should be implemented in practice.

User-centred care seems to be particularly challenging at night due to short and targeted interventions, which include many intimate situations such as turning someone in bed, helping them to use the toilet, or changing diapers (cf. Andersson and kalman 2017).

The way user-centred care is approached by the interviewees also reveals something about the working routines of eldercare organization and the new documentation systems that were commonly implemented in the municipalities in order to secure care recipients' rights. However, this raises questions of how individual needs should be interpreted and what user-centred care actually means in practice.

The care managers who assessed the needs of older people usually had standard times for certain interventions, like 'safety visits'. 'There are no safety visits that only take five minutes' (3:2 care worker). She further argued that the safety visits created dignity and safety at night. Overall, the care workers stated that there was not enough time to listen to the recipients or to give some extra care.

Relatedness; summing up: the care workers' perspective on good care as mainly conditioned by time

Even if time seemed to be a prerequisite for dignity, this was not always the case. Sometimes dignified care was disconnected from time, with the main focus being related to the situation at hand:

> They said that we should never lift her up anymore, but I know that if we stop lifting her up from the bed, she will soon be dead. She needs to get up, because she has itching due to the plastic sheet, she is so warm, she needs to get up. Then she sits on the portable toilet seat and I comb her hair. And then she is hungry, she has her last meal at four p.m., and we arrive at midnight, you can imagine yourself. Then I give her compote and milk and she is so grateful (4:3 care worker).

This quote is very illustrative of how all these seemingly practical things mean dignity and respect for the care recipient when focussing on relatedness. Instead of following the other night teams' routines around this woman (and perhaps also ignoring the care manager's needs assessment), this night team focused on the relational tasks that they identified as being connected to the older woman. This care worker did not talk about the available time for the visit. This also illustrates that individual responsibility for the care recipient was taken, regardless of what the routines or the work schedule said to do or how much time it should take to do them. This example illustrates the care worker's genuine care for the woman, containing relational aspects of care as being based on mutuality and trust (Eliasson 1992; Noddings 1984; Szebehely 1995).

Good and dignified care were also related to being on time. However, it was not always easy for the care workers to be on time; if they got an alarm from someone else, then they had to take that first. Even though the recipients could not be promised an exact time, they had an approximate time, but sometimes the care workers got to someone later than scheduled: 'Before we had time, but

not anymore, and that can result in more alarms and feelings of insecurity among the recipients' (3:2 care worker). Here the care worker gives a retrospective view of night-time care to explain the lack of time, being aware that not being able to be on time might result in a vicious circle of more alarms due to feelings of insecurity among the care recipients.

Our analysis of the care workers' expressions of good and dignified care show that they related to night-time care work practice seeing the dignity policy as something unrealistic coming from above. Most important for good and dignified care was time for care, which often was missing.

Good and dignified care in night-time care as fundamentally relational (?)

In comparison with Miller's (2017) three themes inspired by relationality and ethics of care, our analysis points at perceptions of dignity at night-time as basically reflecting how good care is perceived as relational. In our analysis, the care unit managers had clear views of good and dignified care, in which the staff's competence and ability to care were important (cf. Pols 2013). Expressions of continuity, the staff's caring attitude and responsiveness, and being sensitive and flexible were highlighted, which can be related to Miller's (2017) first theme, care as dignifying by emphasizing manners, a caring attitude, and how to care well. The analysis also revealed user-centredness and the safety of the vulnerable older people by emphasizing sensitivity to their individual needs and wishes in night-time care. Furthermore, the care unit managers perspective revealed above all their administrative role when acknowledging the staff's competence and the challenges of night-time care work. Here the managers indirectly expressed relational care and concern for the care recipients and the care working staff.

The analysis of the care workers' perceptions of dignity and dignified care were about having time for relational aspects of care, as well as placing care recipients at the centre of night-time care. Here we can trace ideas of Miller's (2017) second theme concerning the moral power of care by accentuating the skills and actions of good caring. More practical dimensions like resources of care were also important for dignity at night, not least having a safety alarm and decent living conditions.

There were several reported challenges connected with night-time care. In contrast to daytime care, the work is more unpredictable, and many short visits and many alarms can change the whole time schedule at night due to cases of falls or other accidents (Andersson and kalman 2017). Furthermore, even if many of the older people are asleep, not everyone is. Retaining continuity in staff was also reported to be a challenge at night, which in turn also affects user-centred care in terms of focusing on individual care in trying to respect the recipient's needs and wishes. The short nature and frequency of visits at night, consisting mostly of targeted interventions such as intimate care, results in challenges both for the care workers and the care recipients. Could it be that the working conditions for night-time care set limits for good dignified care?

So what does our analysis actually reveal and what is new? Perhaps nothing is new. The interviewed groups all responded to reflections of dignity by accentuating relational aspects of care, and what constitutes good care, which is similar to other care research. Dignity was perceived by some staff as an ideal goal coming from an organizational level, but which in practice is impossible to relate to because dignity should include self-determination and influence of care. As some of the care workers expressed, there is no 'real' dignity, and this instead refers to something that looks good on paper, but can never be fulfilled. Furthermore, lack of time sets limits for doing anything extra, such as sitting down and talking with some recipients.

Even if dignified care seems to be conditioned by time and the short timeframe for each visit at night, some care worker teams preferred to refer to being related to the situation, rather than to time limits. This approach is best described by social care researchers referring to as 'genuine caring' in terms of mutuality and trust by enhancing the relational aspects of care and taking individual responsibility for the care recipient (Eliasson 1992; Noddings 1984; Szebehely 1995). Even if most care workers referred to personal traits such as being flexible and responsive, the practical dimensions of night-time care were also of importance. Taken together, there seemed to be two kinds of

perceptions of dignity – one reflected caring attitudes and actions as relational (cf. Miller 2017), which to our interviewed groups appeared as basically self-evident, and the other representing dignity as a vague concept with the unreachable goals of having influence and self-determination, mainly constructed on the policy level based on individuality.

Concluding discussion

The focus of this article has specifically been on how dignity is perceived in care practice at night-time within home care services in Sweden, which in itself is a knowledge gap in public eldercare. Swedish legislation regarding the goals of dignity and wellbeing within eldercare (SFS 2010: 427 law change of SFS 2001: 453) generally appeared to be an abstract goal according to our analysis of the case study. There was a relative lack of awareness of the dignity policy per se, and there was no guidance to follow in night-time care. Furthermore, the care unit managers felt devalued and left out from eldercare policies of the municipality, and thus the dignity policy became poorly matched with night-time care. This reveals not only a gap between policy and practice, but also implicit perceptions of night-time care as being of more temporary character with mainly safety visits provided to sleeping older people.

The dignity policy has been constructed in a political context within social eldercare, resting on assumptions that eldercare lacks quality and the ethical values of dignity (Prop. 2009/10:116). Taken from our analysis of social care practice, the perceptions of dignity were very close to the conceptualization of care ethics by emphasizing responsiveness, receptivity and relational aspects of care and by taking individual responsibility for the care recipient (cf. Noddings 1984; Wærness 1984; Eliasson 1992). Good and dignified care was perceived mainly as relational, thus emphasizing ethical values of care that indeed seemed self-evident for care workers in acting in dignified manners (Miller 2017). However, the way the dignity policy has been interpreted on the local level as guarantees and promises of being on time or having a contact person do not necessarily equate to dignity in practice. The way dignity has been implemented, by having documents on a national and local level with key concepts such as self-determination, influence, and high quality care (SOSFS 2012:3), represents a contractual form of dignity rather than ethical values of care and dignity (Andersson 2018). However, to claim these legislated rights of dignity, the care recipients have to be active consumers of care, which is seldom the case when simultaneously dependent on care (Andersson and Kvist 2015).

What is missing in the articulation of the dignity policy (SOSFS 2012:3) is the working conditions and prerequisites for night-time care especially in times of austerity and structural changes (Meagher and Szebehely 2013; Lloyd and Sullivan 2018). Many and often short visits at night and a lot of car driving – and the risks connected with that – in combination with many vulnerable and dependent care recipients mean that attention must be paid to the structural conditions of night-time care. Taken together, poor working conditions and the challenges of night-time care, including limited time frames, are significant challenges to providing dignified care at night.

Our analysis of night-time care in Sweden shows several challenges for the care unit managers and the care workers to handle and that many of the recipients are in need of extensive care during the night. Hearing the voices from social care practice is thus important. We have also tried to illuminate how expressions of dignity in care practice were already founded in care ethics, regardless of the dignity policy. However, if we implement Miller's (2017) discourse of dignity as mainly relational on the structural policy level, perhaps the care work in eldercare practice can be given more recognition.

Note

1. Dignity 24 hours a day in Swedish elderly care? A survey and analysis of work and organisation in home care servises at night-time (Forte, 2015-00820).

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