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REVIEW ARTICLE

Nursing support for older people's autonomy in residential care: An integrative review

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Abstract

Background: Nurses play a crucial role in enabling older people's autonomy in residential care. However, there is a lack of synthesised knowledge about how nurses can support older people.

Objective: The aim of this study was to identify and synthesise nursing support for older people's autonomy in residential care.

Methods: An integrative review was carried out by searching the CINAHL, Philosopher's index, PubMed, SocINDEX, Scopus and Web of Science databases, supplemented by manual searches. The searches focused on peer-reviewed scientific empirical research papers published in English, without date limitations. The constant comparison method was used for the analysis.

Results: The review identified 24 papers, and these showed that older people's autonomy was based on dignity. Nurses protected older people's autonomy in eight different ways. They protected their right to make their own decisions, acted as advocates, respected their wishes, provided opportunities for autonomy, fostered independence, gave information to residents and relatives, provided individualised care practices and protected older people's safety. However, there were also barriers that needed to be overcome.

Conclusions: Nurses used multiple, individually tailored activities to support older people's autonomy, but they also had different reasons for supporting or hindering it. Work and leadership structures are needed to ensure that older people's autonomy is driven by ethical practices.

Implications for practice: The results of this review can help nurses who provide residential care for older people to recognise the different nursing activities that can be used to support older people's autonomy and to develop strategies to apply them in different daily care situations. However, further research is needed to determine how these activities can be realised in daily care and how they cover different aspects of older people's lives in residential care.

KEYWORDS
autonomy, decision-making, integrative review, nurses, older people, residential care, self-determination

1 | INTRODUCTION

Nurses play an essential role in supporting and enabling the autonomy of older people in residential care (Blomsjö et al., 2006; Nikumaa & Mäki-Petäjä-Leinonen, 2019; Sherwin & Winsby, 2011; Solum et al., 2008). Autonomy refers to how an individual makes their own decisions, according to their own values and views of life (Bölenius et al., 2019; Dryden, 2019), without other people interfering with their decisions (Beauchamp & Childress, 2012). Autonomous decision-making is only possible if an individual has sufficient capacity, information and resources (Welford et al., 2012). However, older people's autonomy can be challenging in residential care. Their capacity for autonomous decision-making can be decreased by somatic diseases, multiple co-morbidities and the mental health consequences of their health issues. This means that older people are increasingly dependent on others for planning and completing their daily activities (Gordon, 2018; Hammar et al., 2014).

In older people residential care, older people have the right to be treated with dignity and have their fundamental right of autonomy be respected (Bentwich et al., 2018a; Universal Declaration of Human Rights, 1948). Nurses working in residential care should aim to support older people's autonomy and compensate for their loss of capacity (Greve, 2017; Sherwin & Winsby, 2011). They can support older people's autonomy by helping to create a respectful resident-centred atmosphere, where there are meaningful relationships between older people and healthcare professionals (Welford et al., 2010). However, limiting older people's opportunities to make their own decisions by monitoring (Sherwin & Winsby, 2011), controlling (Moller et al., 2006) or restricting decisions (Solum et al., 2008) can threaten or neglect older people's autonomy (Bradshaw et al., 2012; Oosterveld-Vlug et al., 2016; Sherwin & Winsby, 2011).

There are a number of reasons why older people's autonomy is neglected in residential care, including residents not receiving the care they need and healthcare professionals having insufficient time to fully address their daily needs (Scott et al., 2019) or just focusing on their medical needs (Solum et al., 2008). Older people's individual needs are not prioritised when this happens (Suhonen et al., 2018). Nurses have reported that they have witnessed older people being psychologically and physically abused by their colleagues and this behaviour has included violating their autonomy by restricting movement (Bužgová & Ivanovřa, 2011). The reasons for this include care practices that are structured according to strict routines and allow residents very little individuality and opportunities for autonomy (Blomsjö et al., 2006; Sherwin & Winsby, 2011). Older people's autonomy can also be neglected due to institutional characteristics, such as the allocation of nursing resource (Scott et al., 2019) or staff shortages, the characteristics of the nurses or the older person's situation, such as isolation from their family members (Bužgová & Ivanová, 2009).

Previous reviews that have focused on older people's autonomy in residential care have looked at subjects such as what factors enable or prevent autonomy in care facilities (Sikorska-Simmons & Wright, 2007; Welford et al., 2012). According to these reviews, it is crucial to understand the care practices that influence older people's autonomy in residential care. However, there is a lack of synthesised knowledge on how nursing can support older people's autonomy in residential care.

Summary statement of implications for practice

What does this research add to existing knowledge in gerontology?

- Older people's autonomy should be placed at the centre of residential nursing care.
- Nurses can have different reasons for supporting or hindering older people's autonomy.

What are the implications of this new knowledge for nursing care with older people?

- Nurses can support autonomy by protecting older people's own decisions, advocating for them, respecting their wishes, providing opportunities for decisions and fostering independence.
- There can be numerous barriers to older people's autonomy, such as care practices, nurses' attitudes, safety issues, families' views and older people's health.

How could the findings be used to influence policy or practice or research or education?

- The findings can be used to recognise different nursing activities that support older people's autonomy. However, further research is needed to determine how these activities can be delivered during daily care.
- Nurses need to be familiar with the ethical value of autonomy and ensure that it is reflected in any ethical decisions they make
- Guided ethical discussions, continuing education and ethically sensitive care practices are needed to ensure that older people's autonomy is considered and realised in residential care.

1.1 | Aim

The aim of this study was to identify and synthesise the nursing support available for older people's autonomy in residential care. The research questions were as follows: (i) how did nurses describe the content and meaning of older people's autonomy and (ii) what kind of nursing support enabled older people's autonomy?

2 | METHODS

We used the integrative review method to identify and synthesise previous knowledge that was produced using different research methods (Whittemore & Knafl, 2005).

2.1 | Literature searches

The most appropriate search terms, and their combinations, were based on preliminary literature searches and developed in collaboration with an informatics expert. MeSH and free search terms were combined to describe the autonomy of older people in residential care, and the results are reported from a nursing perspective. The electronic searches were conducted using the CINAHL, Philosopher's Index, PubMed, SocINDEX, Scopus and Web of Science databases. These were supplemented by manually searching the reference lists of the selected papers. We did not set any date limitations, but the studies had to be scientific peer-reviewed empirical papers that were published in English (Figure 1).

2.2 | Literature selection and search outcomes

The selection was independently conducted by two authors (TM and MK) using the Sample, Phenomenon of Interest, Design, Evaluation, Research Type inclusion and exclusion criteria (Cooke et al., 2012; Figure 1). Our inclusion criteria were that the study informants were nurses or nursing managers, that the focus was on older people's autonomy in residential care and that the paper was an empirical study. We included papers if at least one data collection settings was residential care and this meant that papers were considered if they also included other additional settings. We excluded studies that were reviews, commentaries, case studies or editorials.

2.3 | Data evaluation

We evaluated the methodological quality of the selected papers using the Mixed Methods Appraisal Tool (MMAT) (Pluye & Hong, 2014), which is designed for papers that use various different

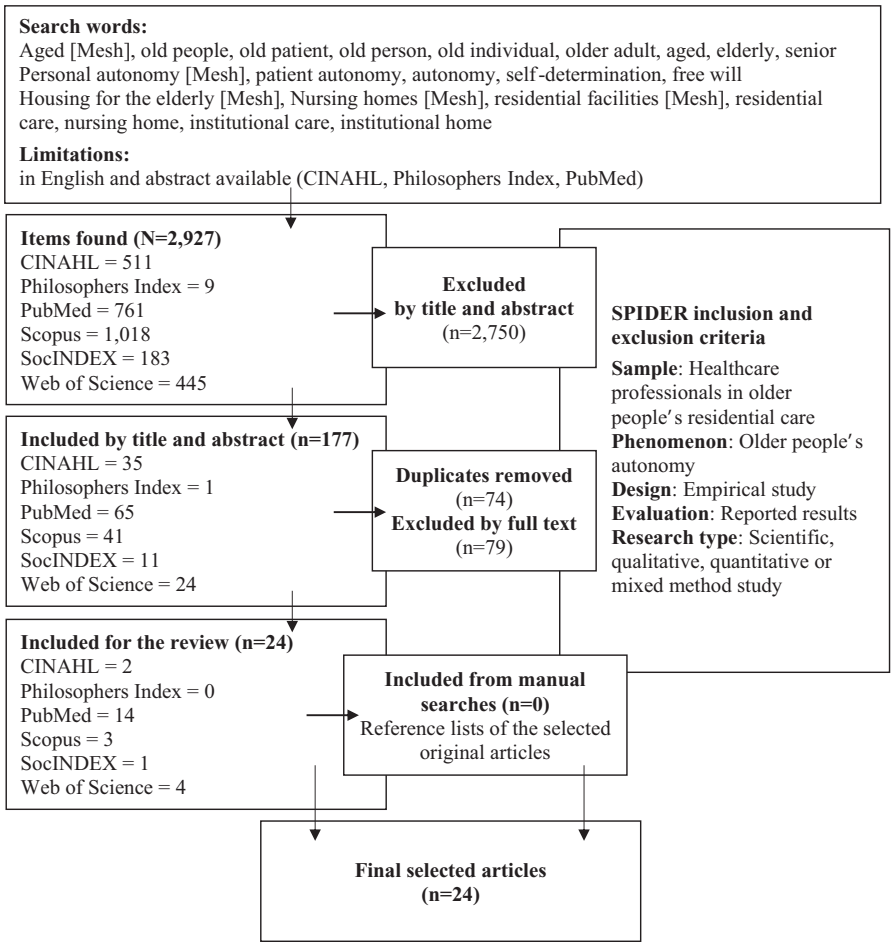

FIGURE 1 Flowchart of literature searches

methods. There are six questions for quantitative studies, six for qualitative studies and five for mixed-method studies, with one point for yes and zero for no or unclear cases. The evaluation was independently conducted by two researchers (TM and MK).

2.4 | Data analysis and synthesis

We analysed the data by the constant comparison method, using the NVivo 12 plus program. First, the selected papers were read thoroughly to get an overview of the content, and then, we tabulated them according to the aim, methods and results of the studies. Next, we identified and extracted the content of the studies, focusing on nursing activities that supported older people's autonomy. We coded text items inductively using the NVivo program and grouped them based on their similarities and differences. The groups were constantly compared to the individual studies, and the total results, to ensure the coverage and representativeness of the data (Boeije, 2002; Olson et al., 2016).

3 | RESULTS

3.1 | Description of the selected studies

The electronic searches resulted in 2,927 papers, and we reviewed 177 based on their title and abstract and 24 based on their full text. The manual searches resulted in six more potential papers, but none of them met our inclusion criteria. This means that 24 empirical research papers were included in the final analysis (Figure 1).

The reviewed papers were published between 1985 and 2018 (Tables 1-3). Seven were from the United States, four were from the United Kingdom, three from Israel, two from the Netherlands, Norway and Sweden and one each from Canada, China, Israel and Hong Kong. Of the selected papers, 14 used qualitative research methods, eight used quantitative methods and two were carried out using mixed methods. The qualitative data collection methods included semi-structured and in-depth, individual, dual and focus group interviews and observations. The quantitative data were collected using self-response questionnaires and surveys. The participants in the studies were nursing professionals, including registered nurses, nursing assistants and nurse managers. The number of participants varied from seven to 285 in the qualitative papers, from 84 to 887 in the quantitative papers and from 19 to 220 in the mixed-method papers. All the data relevant to our study were collected from older people's care settings, such as assisted living facilities, care homes, hospitals, long-term care facilities, nursing homes and residential care. Only the three papers by Bentwich et al. (2017), Bentwich et al. (2018a), Bentwich et al. (2018b) included additional hospital settings.

The methodological quality of the selected papers was assessed using the MMAT, and all the scores indicated adequate confidence in the results. The qualitative studies ranged from three to six (Table 1), the quantitative papers from two to six (Table 2) and both the mixed-method papers scored four (Table 3). The main weakness in all the papers we included were the poorly reported ethics in the methods sections.

Based on our results, nurses perceived that autonomy is the basic principle and part of quality care, influenced by nurses' personal characteristics. Supporting autonomy consisted on protecting older people's rights, acting as advocates and respecting older people's wishes. In addition, nurses perceived that they could support older people's autonomy by providing opportunities, fostering independence and providing information for older people and their families. Individualising care practices and protecting safety were also recognised as supporting actions for autonomy.

3.2 | Nurses' perceptions of older people's autonomy

Based on our findings, nurses recognised that dignity created a basis for older people's autonomy (Bentwich et al., 2018a; Boisaubin et al., 2007) and they referred to the right of individuals to make their own decisions (Chan & Pang, 2007; Zhai & Qiu, 2007). In addition, autonomy was connected to residents being able to enjoy their freedom (Chan & Pang, 2007) and independence (Oakes & Sheehan, 2012). Enabling autonomy meant that older people were treated with respect in residential care (Bentwich et al., 2018a; Bentwich et al., 2018b; Boisaubin et al., 2007; Chan & Pang, 2007; Zhai & Qiu, 2007). The nurses emphasised varying ethical aspects of older people's autonomy, which were implemented in their care practices (Van Thiel & Van Delden, 2001). However, they also found it difficult to identify the values that those activities were based on. Instead of older people's autonomy, some nurses described principles of beneficence and non-maleficence. (Dreyer et al., 2010).

Enabling older people's autonomy was seen as part of the nurses' work and how they provided quality care (Murphy, 2007). In addition, nurses said that sometimes they supported older people's autonomy to ease their own workload. However, some nurses said that older people's autonomy could also increase their workload. For example, if a person with incontinence did not have to wear continence aids, the professionals had to deal with the consequences, including soiled clothes and furniture and the unpleasant smell (Oakes & Sheehan, 2012).

Studies found that nurses' personal characteristics influenced their perceptions of autonomy in residential care. Differences were explained by religion (Bentwich et al., 2017, 2018a), country of origin (Bentwich et al., 2017, 2018a, 2018b; Mullins & Hartley, 2002; Scott, Välimäki, Leino-kilpi, Dassen, Gasull, Lemonidou, Arndt, Schopp et al., 2003) and education (Bentwich et al., 2017, 2018a; Mullins & Hartley, 2002). In addition, fear of physical violence from the residents, the norms of society (Bentwich et al., 2017, 2018a) and nurses' professional backgrounds influenced their perceptions of autonomy. For example, hospital nurses valued autonomy more highly than those working in nursing homes (Bentwich et al., 2017, 2018a,

TABLE 1 Characteristics of the 14 qualitative studies included in the review

Author(s), year, country	Aim	Method and data collection	Main results	Quality* (Max 6)
Barmon et al., 2017, USA	To examine how staff and managers discuss residents' right for sexual freedom in assisted living.	Individual interviews with managers ($n = 6$), staff members ($n = 22$), residents ($n = 24$) and family members ($n = 9$). Focus groups with staff members ($n = 27$).	Professionals used surveillance, which undermined older peoples' autonomy and rights for sexual freedom.	(i) y (ii) y (iii) y (iv) n (v) y (vi) yTotal 5
Bentwich et al., 2018, Israel	To explore differences among caretakers in their attitudes towards dementia patients' autonomy and dignity.	Semi-structured interviews with formal care takers ($n = 20$) from different cultures: Sabras, Arabs and Russians.	Arab professionals seemed to offer richer perceptions of older peoples' autonomy than professionals from other ethnic groups.	(i) y (ii) y (iii) y (iv) y (v) y (vi) nTotal 5
Boisaubin et al., 2007, USA	To explore perceptions of autonomy, dignity, quality of care and decision-making in long-term care.	Semi-structured interviews with residents ($n = 4$), family members ($n = 10$) and healthcare professionals ($n = 9$).	Professionals reported that older people should make their own treatment decisions, as long as they were capable. Shared decision-making with older people and relatives was also emphasised.	(i) y (ii) y (iii) y (iv) n (v) y (vi) nTotal 4
Chan & Pang, 2007, Hong Kong	To examine perceptions about individual dignity and autonomy, quality of care and financing of long-term care.	In-depth semi-structured interviews with older people ($n = 6$), family members ($n = 10$), administrators ($n = 6$) and healthcare professionals ($n = 7$).	Professionals agreed that older people should make their own decisions, as long as they were capable to do so. If not, relatives should be involved in decision-making.	(i) y (ii) y (iii) y (iv) y (v) y (vi) nTotal 5
Dreyer et al., 2010, Norway	To examine how healthcare professionals protected patients' autonomy in end-of-life decisions.	In-depth interviews with nurses ($n = 10$) and physicians ($n = 9$)	Professionals' assessment of older peoples´ competence to consent was almost non-existent. Nurses trusted older people's decisions more than physicians did.	(i) y (ii) y (iii) y (iv) y (v) y (vi) nTotal 5
Evans et al., 2018, UK	To determine how managers' conflict negotiation enabled autonomy and maintained safety.	Semi-structured interviews with managers ($n = 18$)	Respondents described balancing older peoples' autonomy with the need to protect them and their dignity.	(i) y (ii) y (iii) y (iv) y (v) y (vi) nTotal 5

(Continues)

TABLE 1 (Continued)

Author(s), year, country	Aim	Method and data collection	Main results	Quality* (Max 6)
Hawkins et al., 2011, UK	To examine how healthcare workers supported residents' autonomy by enabling independence.	Observations and semi-structured interviews with staff ($n = 14$) and residents ($n = 8$).	Professionals reported conflicts between respecting residents' autonomy and their own duty of care.	(i) y (ii) y (iii) y (iv) y (v) y (vi) yTotal 6
Hedman et al., 2019, Sweden	To describe registered nurses' experiences of promoting autonomy and participation.	Semi-structured individual interviews with nurses ($n = 13$)	When nurses promoted older peoples' autonomy, they considered factors such as their frailty, the impact of their illness and trusting relationships with older people, relatives and other professionals.	(i) y (ii) y (iii) y (iv) y (v) y (vi) nTotal 5
Oakes & Sheehan, 2012, USA	To examine how healthcare professionals gave meaning to autonomy in assisted living.	In-depth interviews with managers ($n = 9$) and aides ($n = 18$).	Professionals considered older peoples' autonomy as a synonym for independence and tried to achieve it in the best interests of older people.	(i) y (ii) y (iii) y (iv) y (v) y (vi) nTotal 5
Solum et al., 2008, Norway	To investigate caregivers' perceptions of moral alternatives in daily care.	Observations and interviews with caregivers ($n = 7$)	Professionals described older peoples' right to be seen and heard and their right to autonomy when they were competent to make own decisions.	(i) y (ii) y (iii) y (iv) y (v) y (vi) nTotal 5
Tufford et al., 2018, Canada	To examine locked door and physical restriction practices and justifications for those in long-term care facilities.	Observations and interviews with managers, healthcare workers, residents and family members ($n = 285$)	Locked doors and other physical restrictions decreased older peoples' opportunities to be autonomous in residential care.	(i) y (ii) y (iii) y (iv) n (v) y (vi) nTotal 4
Whitler, 1996, USA	To explore how nurses assisted elderly nursing home residents to preserve their autonomy.	Interviews with nurses ($n = 25$)	Professionals supported older peoples' autonomy by personalising, informing, persuading, shaping circumstances, considering, providing opportunities and assessing why people lacked the capacity to make decisions.	(i) y (ii) y (iii) y (iv) n (v) y (vi) nTotal 4

(Continues)

TABLE 1 (Continued)

Author(s), year, country	Aim	Method and data collection	Main results	Quality* (Max 6)
Wikström & Emilsson, 2014, Sweden	To explore opportunities for autonomy in institution-based housing.	Focus group interviews ($n = 50$) and observations, including residents ($n = 17$), family members ($n = 10$), staff ($n = 12$) and managers ($n = 11$)	Autonomy was not a reality for older people, due to professionals' power to make decisions. Professionals also perceived that older people were unable to achieve autonomy.	(i) y (ii) y (iii) y (iv) y (v) y (vi) nTotal 5
Zhai & Qiu, 2007, China	To study perceptions about long-term care for older people.	Interviews with older people ($n = 6$), family members ($n = 10$), assistant nurses ($n = 4$), physicians ($n = 3$) and administrators ($n = 3$)	Professionals said that older people should make their own decisions, as long as they were competent to do so and that their wishes should be respected. Relatives were also seen as decisions makers for older people.	(i) n (ii) y (iii) y (iv) n (v) y (vi) nTotal 3

(i) Are there clear qualitative and quantitative research questions, or a clear mixed methods question?

(ii) Do the collected data allow address the research question (objective)?

(iii) Are the sources of qualitative data (archives, documents, informants, observations) relevant to address the research question (objective)?

(iv) Is the process for analysing qualitative data relevant to address the research question (objective)?

(v) Is appropriate consideration given to how findings relate to the context, for example the setting, in which the data were collected?

(vi) Is appropriate consideration given to how findings relate to researchers' influence, for example through their interactions with participants?

*MMAT criteria for qualitative studies according to Pluye and Hong (2014)

TABLE 2 Characteristics of the eight quantitative studies included in the review

Author(s), year, country	Aim	Method and data collection	Main results	Quality*(Max 6)
Bentwich et al., 2017, Israel	To identify gaps in attitudes to human dignity and autonomy of professional caretakers from differing cultural backgrounds.	Questionnaires for professional caretakers ($n = 210$) from Israel ethnocultural groups: Russian, Arab and Sabra.	Professionals' attitudes to older peoples' autonomy and dignity varied between ethnocultural backgrounds.	(i) y (ii) y (iii) y (iv) y (v) y (vi) yTotal 6
Mullins & Hartley, 2002, USA	To examine how care was provided in nursing homes.	Survey for healthcare professionals ($n = 202$).	Professionals' education and race affected their perceptions of older people's autonomy.	(i) y (ii) y (iii) y (iv) n (v) y (vi) yTotal 5
Murphy, 2007, Ireland	To determine factors associated with quality care in a long-term care setting.	Questionnaire completed by nurses ($n = 498$)	Nurses stated that promoting older peoples' autonomy and independence contributed to the quality of care.	(i) y (ii) y (iii) y (iv) y (v) y (vi) yTotal 6
Ryden, 1985, USA	To delineate characteristics of residents' interpersonal, organisational and physical aspects of autonomy.	Semi-structured questionnaire for residents ($n = 113$), professional caregivers ($n = 137$) and administrative personnel ($n = 10$).	Professionals saw themselves as the predominant decision makers. Older people only made decisions about one-to-one and solitary activities.	(i) y (ii) y (iii) y (iv) y (v) y (vi) nsTotal 5
Scott, Välimäki, Leino-kilpi, Dassen, Gasull, Lemonidou, Arndt et al., 2003, UK	To examine elderly people's views about autonomy, privacy and informed consent.	Questionnaire completed by staff ($n = 160$) and structured interviews with elderly residents ($n = 101$)	Professionals reported that they gave older people opportunities for decision-making. More than half felt that older people were fully informed.	(i) y (ii) y (iii) y (iv) y (v) y (vi) nTotal 5
Scott, Välimäki, Leino-kilpi, Dassen, Gasull, Lemonidou, Arndt, Schopp et al., 2003, UK	To examine autonomy in healthcare institutions in European countries.	Patients ($n = 573$), healthcare professionals ($n = 887$) in Finland, Spain, Greece, Germany and the UK.	UK professionals were mostly likely to offer older people the chance to make decisions. Opportunities were lowest in Finland.	(i) y (ii) y (iii) ns (iv) ns (v) ns (vi) nsTotal 2

(Continues)

TABLE 2 (Continued)

Author(s), year, country	Aim	Method and data collection	Main results	Quality*(Max 6)
van Thiel & van Delden, 1997, Netherlands	To examine nurses' opinions of respect for autonomy and high-quality nursing home care.	Questionnaire for nurses ($n = 84$)	Respect for older peoples' autonomy was considered problematic, due to competence of the residents and conflicts with care practices.	(i) n (ii) y (iii) n (iv) y (v) y (vi) nsTotal 3
van Thiel & van Delden, 2001, Netherlands	To examine respect for older people's autonomy and moral intuition.	Vignette-based surveys for nurses ($n = 94$) and physicians ($n = 31$)	Professionals' perceptions of older peoples' autonomy varied in relation to different circumstances.	(i) y (ii) y (iii) y (iv) y (v) y (vi) nsTotal 5

(i) Are there clear qualitative and quantitative research questions, or a clear mixed methods question?

(ii) Do the collected data allow address the research question (objective)?

(iii) Is the sampling strategy relevant to address the quantitative research question?

(iv) Is the sample representative of the population understudy?

(v) Are measurements appropriate?

(vi) Is there an acceptable response rate (60% or above)?

*MMAT criteria for quantitative descriptive studies according to Pluye and Hong (2014)

TABLE 3 Characteristics of the two mixed-method studies included in the review

Author(s), year, country	Aim	Method and data collection	Main results	Quality* (max 5)
Bentwich et al., 2018, Israel	To explore professional caretakers' perceptions of autonomy and human dignity of dementia patients.	Semi-structured interviews with caretakers ($n = 20$) and questionnaires completed by professional caretakers ($n = 200$)	Professionals' perceptions of older people's autonomy varied in relation to the care facility and country and ethnoculture was identified as the most influencing factor.	(i) n (ii) y (iii) y (iv) y (v) yTotal 4
Taverna et al., 2014, USA	To examine the effect of autonomy on residents' oral hygiene.	Individual structured interviews with residents ($n = 12$) and care staff ($n = 7$) care staff.	By respecting older people's independence, professionals enabled excessive autonomy to occur.	n y y y y Total 4

(i) Are there clear qualitative and quantitative research questions, or a clear mixed methods question?

(ii) Do the collected data allow address the research question (objective)?

(iii) Is the mixed methods research design relevant to address the qualitative and quantitative research questions (or objectives), or the qualitative and quantitative aspects of the mixed methods question (or objective)?

(iv) Is the integration of qualitative and quantitative data (or results*) relevant to address the research question (objective)?

(v) Is appropriate consideration given to the limitations associated with this integration, for example the divergence of qualitative and quantitative data (or results*) in a triangulation design?

*MMAT criteria for mixed-method studies according to Pluye and Hong (2014)

2018b). Nurses who worked in nursing homes that provided intermediate care exercised a higher level of control over older people than professionals working in specialised nursing care (Ryden, 1985). However, one study reported that nurses who worked in facilities that emphasised older people's autonomy reported less job satisfaction and more negative attitudes towards older people than those who worked in facilities that did not. This was seen to highlight the need for in service training regarding the meaning of autonomy as part of higher quality of life, prior nurses working practices. (Mullins & Hartley, 2002.)

3.3 | Nursing support for older people's autonomy

Nursing activities that supported older people's autonomy in residential care were described as protecting older people's rights to make their own decisions, acting as advocates, respecting their wishes, giving them opportunities, fostering independence and providing information. In addition, key activities that supported autonomy were identified, such as individualising care practices and protecting older people's safety.

3.3.1 | Protecting people's rights to make their own decisions

Nurses recognised that older people had the right to make their own decisions (Barmon et al., 2017; Boisaubin et al., 2007; Chan & Pang, 2007; Oakes & Sheehan, 2012; Zhai & Qiu, 2007), as long as they were cognitively and mentally competent to do so (Boisaubin et al., 2007; Chan & Pang, 2007; Whitler, 1996). This was because older people had the rights and responsibilities to make their own decisions (Barmon et al., 2017; Chan & Pang, 2007; Zhai & Qiu, 2007), and they also had the right to have a good quality of life. However, nurses were not always able to assess older people's capacity, and the consequences for their autonomy, if they were judged incapable of making decisions (Whitler, 1996).

Nurses said that they had a responsibility to protect older people's rights to make their own decisions (Chan & Pang, 2007; Van Thiel & Van Delden, 1997). That included finding ways to make older people's decisions visible, minimising the potential risk of those decisions (Chan & Pang, 2007) and achieving the main goal, which was that older people had to be the main decisions makers if they were competent to make their own choices (Boisaubin et al., 2007; Zhai & Qiu, 2007). If an older person was not competent to make decisions by themselves, professionals and family members should help them by providing information and advice (Zhai & Qiu, 2007) or family members should make decisions for them (Boisaubin et al., 2007; Chan & Pang, 2007; Zhai & Qiu, 2007). However, nurses had a tendency to assume that older residents had limited capacity for decision-making and they took on the role of key decision makers (Ryden, 1985). In addition, they said they made decisions in the best interests of older people (Wikström & Emilsson, 2014).

3.3.2 | Acting as advocates

Nurses described themselves as older people's advocates (Dreyer et al., 2010), based on their education, experiences and interest in caring for older people (Hedman et al., 2019). The aim of advocacy has been described as preserving, and enhancing, older people's autonomy by providing resources that could help them to make decisions and seek potential solutions to problems. Examples have included nurses re-organising older people's rooms in accordance with their wishes (Whitler, 1996) and helping them to maintain social relationships with their families and friends (Chan & Pang, 2007). However, researchers reported that some nurses failed to help older people to preserve their autonomy (Whitler, 1996). This could have been because they did not understand autonomy or their duty to advocate on behalf of residents (Evans et al., 2018; Solum et al., 2008). In addition, some nurses held ageist attitudes and believed that older people were unable to exercise their autonomy. This resulted in them creating barriers that stopped older people making decisions and exercising their autonomy (Wikström & Emilsson, 2014).

3.3.3 | Respecting older people's wishes

Nurses said that respecting older people's wishes with regard to their daily activities was one of the main ways that they supported their autonomy (Klaassens & Meijering, 2015; Zhai & Qiu, 2007). When older people were incapable of stating their preferences, professionals tried to observe their activities to identify what they wanted (Chan & Pang, 2007; Dreyer et al., 2010). Nurses used advance directives to respect and follow older people's wishes with regard to decision-making. However, they expressed concerns that care plans that were written 10 years ago were outdated and did not reflect the current wishes of older people. Nurses also reported that advance directives had failed to acknowledge family members' wishes or the duty of professionals to take care of older people when that care contradicted their wishes (Chan & Pang, 2007). Respecting older people's needs and wishes was a balancing act between the residents' health and their safety (Evans et al., 2018; Klaassens & Meijering, 2015) and independence (Evans et al., 2018; Oakes & Sheehan, 2012). Meeting the needs of one person was time-consuming, and it could stop them from meeting the needs of other residents. This could then jeopardise their autonomy (Evans et al., 2018; Wikström & Emilsson, 2014).

However, some nurses also refused to act in accordance with older people's wishes, due to lack of perseverance or limited resources, such as not enough time to meet their needs (Solum et al., 2008). In addition, nurses acknowledged that they had to disregard some of the older people's wishes in order to meet their families' expectations (Barmon et al., 2017; Chan & Pang, 2007; Dreyer et al., 2010). This could lead to nurses pressuring older people to follow the wishes of their families (Barmon et al., 2017; Oakes & Sheehan, 2012; Solum et al., 2008)

3.3.4 | Providing opportunities

Nurses supported older people's autonomy by presenting opportunities for decision-making (Ryden, 1985; Scott, Välimäki, Leino-kilpi, Dassen, Gasull, Lemonidou, Arndt et al., 2003; Scott, Välimäki, Leino-kilpi, Dassen, Gasull, Lemonidou, Arndt, Schopp et al., 2003; Van Thiel & Van Delden, 1997; Whitler, 1996), such as food and care practices (Hedman et al., 2019). They also involved older people in the inter-professional meetings where their treatment was discussed (Klaassens & Meijering, 2015; Van Thiel & Van Delden, 1997). In addition, nurses made a variety of activities available for older people, such as singing, playing games or going outdoors, and let them choose which ones they took part in (Hedman et al., 2019).

Nurses also refrained from mentioning opportunities for decision-making to older people (Mullins & Hartley, 2002; Whitler, 1996) and made the decisions themselves (Ryden, 1985). This resulted from a lack of dialogue with older people (Solum et al., 2008), assumptions that older people should have little say about their lives in facilities (Ryden, 1985) or nurses feeling that residents should be satisfied with what they were offered (Wikström & Emilsson, 2014). Despite prevailing ethical values (Whitler, 1996), or standardised criteria for high-quality care (Van Thiel & Van Delden, 1997), nurses did not speak to older people or their representatives when planning care and did not seek their consent (Van Thiel & Van Delden, 1997; Whitler, 1996). This could have been because they had limited awareness of autonomy or the misconception that not protesting meant consent (Whitler, 1996).

3.3.5 | Fostering independence

Nurses supported older people's autonomy by making the most of their capacity (Bentwich et al., 2018a, 2018b; Boisaubin et al., 2007), and this led to older people acting as independently as possible. That included protecting and promoting older people's health (Oakes & Sheehan, 2012) with regular health checks (Hedman et al., 2019; Van Thiel & Van Delden, 1997) and supporting them to maintain functional capabilities, such as getting dressed and eating without assistance. However, nurses needed to know older people and their behaviour well in order to foster their independence (Hedman et al., 2019).

Nurses also supported older people's autonomy by refusing to help them with tasks that they knew they could perform independently (Oakes & Sheehan, 2012). However, they also used older people's autonomy as an excuse for not helping them and expecting them to take total responsibility for their own daily activities (Taverna et al., 2014). Nurses also said that older people's independence could involve risks that were not in their own best interests (Hawkins et al., 2011; Solum et al., 2008). In these situations, nurses could limit older people's decision-making to protect their health and well-being (Oakes & Sheehan, 2012).

3.3.6 | Providing information for older people and their families

Providing information for older people and their family members was one way of supporting older people's autonomy and decision-making (Scott, Välimäki, Leino-kilpi, Dassen, Gasull, Lemonidou, Arndt, Schopp et al., 2003). This included providing older people and their families with information about the residents' health and daily lives and the risks and benefits of proposed interventions (Hedman et al., 2019; Whitler, 1996). However, the meaningfulness and importance of the information varied (Van Thiel & Van Delden, 1997), and it could include persuading older people to make decisions (Whitler, 1996).

3.3.7 | Individualising care practices

Individualised care practices were an essential nursing activity, as they promoted older people's autonomy. They also provided starting points for care, by considering their individuality and their potential vulnerability to illness (Hedman et al., 2019). These care practices referred to individualising daily routines (Hawkins et al., 2011; Van Thiel & Van Delden, 1997), such as the timing and frequency of showers, rest and sleep (Hedman et al., 2019) and trying to initiate activities that older people would enjoy (Klaassens & Meijering, 2015). They also included providing a physical environment (Ryden, 1985) that ensured that older people had free access to different parts of the facility (Ryden, 1985; Tufford et al., 2018), including outdoor spaces (Evans et al., 2018). This individual approach to care also helped older people and their families to develop a better understanding of the residents' situations, and the different aspects involved in potential decisions (Whitler, 1996).

Nurses noted that knowing older people and having discussions with them played an important part in creating individualised daily activities (Hedman et al., 2019; Oakes & Sheehan, 2012). This enabled them to have control over their personal situation (Ryden, 1985) and helped nurses to re-organise care routines in collaboration with other professionals (Klaassens & Meijering, 2015). Strict care practices and unspoken rules were perceived as a hindrance to older people's autonomy (Barmon et al., 2017; Hawkins et al., 2011; Hedman et al., 2019; Oakes & Sheehan, 2012) and some nurses reported medicating older people to calm them down, without using individualised care practices to try and find other solutions (Solum et al., 2008).

3.3.8 | Protecting safety

Protecting the safety (Barmon et al., 2017; Boisaubin et al., 2007; Hawkins et al., 2011; Solum et al., 2008) and privacy of older people facilitated their autonomy and dignity (Bentwich et al., 2018a, 2018b; Boisaubin et al., 2007). Nurses said that there was a constant

need to balance older people's own decisions with the nurse's duty to protect them from harming themselves (Evans et al., 2018; Oakes & Sheehan, 2012; Solum et al., 2008; Tufford et al., 2018) or other older people (Barmon et al., 2017; Tufford et al., 2018). Nurses followed standardised risk prevention procedures with all older people, without considering their individual abilities or situations (Evans et al., 2018; Hawkins et al., 2011; Wikström & Emilsson, 2014). Protecting older people's safety could also lead to surveillance (Barmon et al., 2017; Evans et al., 2018; Solum et al., 2008) and violations of their autonomy (Barmon et al., 2017; Solum et al., 2008). In addition, inadequate staffing levels could lead to restricting older people from moving, by tying them into their wheelchair to prevent them from falling (Tufford et al., 2018).

4 | DISCUSSION

This integrated review identified how nurses' activities could support older people's autonomy in residential care, by protecting older people's rights to make their own decisions, advocating for them and respecting their wishes, providing them with opportunities for autonomous decisions and fostering independence. In addition, we found that providing information, individualising care and protecting safety promoted older people's autonomy. The review also identified numerous barriers to older people's autonomy, including care practices, staff attitudes, safety issues, the views of families and the residents' mental and physical health. This discussion reflects on the results we identified in relation to two crucial areas. The first was how the support that nurses identified was related to their working methods and how they perceived older people's autonomy. The second was what kind of leadership was needed to apply these methods in residential care.

4.1 | How nurses used different working methods to support autonomy

The studies included in this review presented several different, but interconnected, activities that supported older people's autonomy. These different activities reflected the various research environments that were reported by the studies included in this review. However, they all recognised that autonomy was not a static principle, as it reflected a range of individual factors that were involved in the daily care of older people. The competencies, capacity and resources to make decisions varied between individual older people. Daily care involved a range of factors and residents may have felt more able to make autonomous decisions about some aspects of their lives and less confident about others, especially if they were aspects that made them feel vulnerable (Bradshaw et al., 2012; Oosterveld-Vlug et al., 2013). In addition, people differed when it came to how they perceived autonomy. That was why nurses needed to know what autonomy meant for an individual resident and what kind of perceptions, wishes and needs they had about their daily care. This meant that nurses needed to constantly re-evaluate care routines to identify how they could support older people's autonomy (Lohne et al., 2017; Oosterveld-Vlug et al., 2013) in a particular care situation.

Our results highlight the fact that autonomy needs to be considered alongside other healthcare values and principles, such as beneficence, non-maleficence and safety. For example, our review found that balancing autonomy and safety in daily care could be challenging (Oosterveld-Vlug et al., 2013). Nurses needed to evaluate an individual older person's needs and wishes in relation to their own safety, but they also had to consider the safety of other residents and staff at the same time (Preshaw et al., 2016; Solum et al., 2008). Balancing autonomy and risks means that nurses working in older people's residential care need to be familiar with ethical values, be able to weight up different values in different daily care situations and also be able to justify the reasons for their ethical decisions. Above all, any decisions should guarantee the human dignity of the older people who are involved.

However, perceptions of autonomy and nursing activities that support older people's autonomy are not just based on individual nurses' values and decisions. They also have to consider wider societal and legal contexts. The papers we reviewed reflected different perceptions of older people and their autonomy, as they represented different healthcare systems, laws, regulations and cultural contexts. In addition, because we did not set a start date for our review, the papers covered views expressed over a period of four decades. Despite the different times and contexts covered by the review, there were some similarities. For example, we found that nurses disregarded older people's autonomy based on similar paternalistic attitudes (e.g. Whitler, 1996; Wikström & Emilsson, 2014) or limited human resources (e.g. Evans et al., 2018; Solum et al., 2008). Despite this, the studies provided unanimous support for the view that autonomy was an important ethical value in older people's care. Furthermore, our results demonstrated that older people's autonomy has received increasingly attention in recent years, as half of the papers we reviewed were published after 2010. Our findings showed that nurses supported older people's autonomy in a number of ways in heterogeneous residential care settings. This may have been because all the stakeholders, including the older people, their families and nurses, came from different generations and backgrounds and had different perceptions of what autonomy meant. It would be beneficial if future research also analysed how older people's autonomy has changed over time and in different societies and how it has influenced the ways that nurses have supported older people' care.

4.2 | Enabling nursing activities to support older people's autonomy

Our findings showed that the opportunities that nurses had to support older people's autonomy in residential care were linked to their professional ethics, organisational characteristics and leadership.

Based on our findings, nurses incorporated autonomy as a central value of their professional ethics and it formed an integral part of their ethical work. The critical finding of this review was that nurses supported older people's autonomy when it enabled them to reduce their own workload. However, we also found that helping residents be autonomous could also be more time-consuming, depending on what daily care activities were involved. In some cases, nurses concentrated on their own needs rather than the residents' needs, and sometimes, they medicated residents to calm them down (Solum et al., 2008). This contravened professional ethics, where the main aim is to protect residents' human dignity and provide the best possible care (Kangasniemi et al., 2015; Rejnö et al., 2020). On the contrary, how well a nurse understood professional ethics, and their role as an advocate for older people (Preshaw et al., 2016), could facilitate ethical conduct in residential care. Regardless of this, some studies reported that there was still a need to pay further attention to nurses' ethical competence (Corbi et al., 2019; Hirst et al., 2016; Reader & Gillespie, 2013), including preventing ageism and autonomy violations in residential care.

Sustainably organised work (Bužgová & Ivanová, 2009) and adequate management (Bollig et al., 2017; Bužgová & Ivanovřa, 2011; Hirst et al., 2016; Reader & Gillespie, 2013) have been found to support older people's autonomy and prevent violations. In addition, sufficient staff resources have been shown to strengthen support for older people's autonomy (Bollig et al., 2017; Bužgová & Ivanová, 2009; Glette et al., 2018; Preshaw et al., 2016). However, older people's residential care is currently suffering from challenging working conditions, because of heavy workloads. These kind of pressures have been reported to restrict nurses' abilities to provide older people with individual assistance (Bollig et al., 2017; Chan et al., 2020; Oosterveld-Vlug et al., 2013; Preshaw et al., 2016; Reader & Gillespie, 2013; Solum et al., 2008) and have endangered their feelings of autonomy and dignity (Bollig et al., 2017; Oosterveld-Vlug et al., 2013). Nurses have also reported that stressful atmospheres and lack of appreciation for their work from the people they work with, including managers, can increase risks for autonomy violations (Bužgová & Ivanovřa, 2011).

Although nurse leaders have reported that they understand the importance of supporting older people's autonomy, they do not always have the skills to put these into practice and communicate them to employees (Evans et al., 2018). For example, studies have reported limited awareness among nurses that making decisions on behalf of older people (Bužgová & Ivanová, 2009) or using physical restraints (Kor et al., 2018) may violate their autonomy. Research has shown that this awareness can be increased by guided ethical discussions (Bollig et al., 2017), continuing education and standardised, ethically accepted care practices. In addition, more attention needs to be paid to nurse leaders' competencies. Studies in residential care have been scarce, but research in other nursing fields has found that nurse leaders need more support when it comes to knowledge about ethics in care and, in particular, with regard to leadership strategies in ethics (Poikkeus et al., 2014, 2020). Support for nurse leaders would increase the current knowledge and application of identified nursing support for older people's autonomy in residential care.

4.3 | Limitations

This review had some strengths and limitations. Carrying out an integrative review was an appropriate research method for this subject, because the studies on this topic were heterogeneous (Whittemore & Knafl, 2005). This method enabled us to identify and synthesise major themes and answer our research questions. We used various search terms, together with MeSH terms, and formulated the search phrases in collaboration with a library informatics expert to ensure their validity and to increase methodological rigour. In addition, we conducted manual searches to supplement the electronic searches. We restricted our selection to papers published in English, which could have produced language bias. However, we did not limit the publications dates, which strengthened the coverage of the results. The studies were independently selected by two researchers and conducted in phases, according to previously set criteria. We approved the quality of the papers, which ranged from two to six. It is noteworthy that 10 of the 14 qualitative papers did not report what steps were taken to avoid the researchers influencing the participants during their interaction. In addition, there were issues with how five of the eight quantitative studies reported response rates. We only focused on the views of nurses, even though some of the studies also included other health professionals, such as physicians and managers.

5 | CONCLUSIONS

Older people's autonomy is a key fundamental right that should be placed at the centre of residential care. We identified multiple activities that supported autonomy and that could be individually tailored to meet the needs of older people and provide ethical, high-quality care in residential settings. Older people's autonomy is not a static entity. It can vary between different residents and individuals can feel confident about exercising autonomy in some areas of their daily care, but vulnerable when it comes to other daily activities. The different nursing support activities that are presented in this review can be used to inform how nurses support older people's autonomy in residential daily care, by responding to their individual needs and wishes. Daily decisions about autonomy need to be considered as a part of other healthcare values, but the leading principle should always be to ensure the human dignity of older people. Nurses have an immediate opportunity to influence how older people's autonomy is realised. However, nurse managers and care organisations also need to put structures in place to ensure that older people can benefit from daily autonomy in residential care.

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CONFLICT OF INTERESTS

The authors have no conflict of interest to declare.

AUTHOR CONTRIBUTIONS

TM, MK and RS involved in study design, data collection, data analysis, manuscript writing and critical review.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are openly available in scientific databases according to the reference details of analysed papers.

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REFERENCES

*Included in the review.

*Barmon, C., Burgess, E., Bender, A., & Moorhead, J. (2017). Understanding sexual freedom and autonomy in assisted living: Discourse of residents' rights among staff and administrators. *Journals of Gerontology: Social Sciences*, *72*(3), 457–467. https://doi.org/10.1093/geronb/gbw068

Beauchamp, T., & Childress, J. (2012). *Principles of biomedical ethics*, 7th ed. Oxford University Press.

*Bentwich, M., Dickman, N., & Oberman, A. (2017). Dignity and autonomy in the care for patients with dementia: Differences among formal caretakers of varied cultural backgrounds and their meaning. *Archives of Gerontology and Geriatrics*, *70*, 19–27. https://doi.org/10.1016/j.archger.2016.12.003

*Bentwich, M., Dickman, N., & Oberman, A. (2018a). Human dignity and autonomy in the care for patients with dementia: Differences among formal caretakers from various cultural backgrounds. *Ethnicity & Health*, *23*(2), 121–141.https://doi.org/10.1080/13557858.2016.1246519

*Bentwich, M., Dickman, N., & Oberman, A. (2018b). Autonomy and dignity of patients with dementia: Perceptions of multicultural caretakers. *Nursing Ethics*, *25*(1), 37–53. https://doi.org/10.1177/0969733016642625

Blomsjö, I., Sandman, L., & Andersson, E. (2006). Everyday ethics in the care of elderly people. *Nursing Ethics*, *13*(3), 249–263. https://doi.org/10.1191/0969733006ne875oa

Boeije, H. (2002). A purposeful approach to the constant comparative method. *Quality & Quantity*, *36*(4), 391–409. https://doi.org/10.1023/A:1020909529486

*Boisaubin, E., Chu, A., & Catalano, J. M. (2007). Perceptions of long-term care, autonomy, and dignity, by residents, family and caregivers: The Houston experience. *Journal of Medicine and Philosophy*, *32*(5), 447–464. https://doi.org/10.1080/03605310701626414

Bölenius, K., Lämås, K., Sandman, P., Lindkvist, M., & Edvardsson, D. (2019). Perceptions of self-determination and quality of life among Swedish home care recipients - a cross-sectional study. *BMC Geriatrics*, *19*(1), 1–9. https://doi.org/10.1186/s12877-019-1145-8

Bollig, G., Rosland, J. H., Gjengedal, E., Schmidt, G., May, A., & Heller, A. (2017). A European multicenter study on systematic ethics work in nursing homes. *Scandinavian Journal of Caring Sciences*, *31*(3), 587–601. https://doi.org/10.1111/scs.12373

Bradshaw, S., Playford, E., & Riazi, A. (2012). Living well in care homes: A systematic review of qualitative studies. *Age and Ageing*, *41*(4), 429–440. https://doi.org/10.1093/ageing/afs069

Bužgová, R., & Ivanová, K. (2009). Elder abuse and mistreatment in residential settings. *Nursing Ethics*, *16*(1), 110–126. https://doi.org/10.1177/0969733008097996

Bužgová, R., & Ivanovřa, K. (2011). Violation of ethical principles in institutional care for older people. *Nursing Ethics*, *18*(1), 64–78. https://doi.org/10.1177/0969733010385529

Chan, E., Samsudin, S., & Lim, Y. (2020). Older patients' perception of engagement in functional self-care during hospitalization: A qualitative study. *Geriatric Nursing*, *41*(3), 297–304. https://doi.org/10.1016/j.gerinurse.2019.11.009

*Chan, H., & Pang, S. (2007). Long-term care: dignity, autonomy, family integrity, and social sustainability: The Hong Kong experience. *Journal of Medicine and Philosophy*, *32*(5), 401–424. https://doi.org/10.1080/03605310701631661

Cooke, A., Smith, D., & Booth, A. (2012). Beyond PICO: The SPIDER tool for qualitative evidence synthesis. *Qualitative Health Research*, *22*(10), 1435–1443. https://doi.org/10.1177/1049732312452938

Corbi, G., Grattagliano, I., Sabbà, C., Fiore, G., Spina, S., Ferrara, N., & Campobasso, C. P. (2019). Elder abuse: Perception and knowledge of the phenomenon by healthcare workers from two Italian hospitals. *Internal and Emergency Medicine*, *14*(4), 549–555. https://doi.org/10.1007/s11739-019-02038-y

*Dreyer, A., Førde, R., & Nortvedt, P. (2010). Life-prolonging treatment in nursing homes: How do physicians and nurses describe and justify their own practice? *Journal of Medical Ethics*, *36*(7), 396–400. https://doi.org/10.1136/jme.2010.036244

Dryden, J. (2019). *Autonomy. Internet Encyclopedia of Philosophy. A Peer-Reviewed Academic Resource*. https://www.iep.utm.edu/autonomy/

*Evans, E., Perkins, E., Clarke, P., Haines, A., Baldwin, A., & Whittington, R. (2018). Care home manager attitudes to balancing risk and autonomy for residents with dementia. *Aging & Mental Health*, *22*(2), 261–269. https://doi.org/10.1080/13607863.2016.1244803

Glette, M., Røise, O., Kringeland, T., Churruca, K., Braithwaite, J., & Wiig, S. (2018). Nursing home leaders' and nurses' experiences of resources, staffing and competence levels and the relation to hospital readmissions - A case study. *BMC Health Services Research*, *18*(1), 1–15. https://doi.org/10.1186/s12913-018-3769-3

Gordon, J. (2018). Indignity and old age. *Bioethics*, *32*(4), 223–232. https://doi.org/10.1111/bioe.12434

Greve, B. (2017). Long-term care: what is it about? In B. Greeve (Ed.), *Long-term care for the elderly in Europe. Development and prospects* (pp. 1–7). Routledge.

Hammar, I., Dahlin-Ivanoff, S., Wilhelmson, K., & Eklund, K. (2014). Shifting between self-governing and being governed: A qualitative study of older persons' self-determination. *BMC Geriatrics*, *14*(1), 1–8. https://doi.org/10.1186/1471-2318-14-126

*Hawkins, R., Redley, M., & Holland, A. J. (2011). Duty of care and autonomy: How support workers managed the tension between protecting service users from risk and promoting their independence in a specialist group home. *Journal of Intellectual Disability Research*, *55*(9), 873–884. https://doi.org/10.1111/j.1365-2788.2011.01445.x

*Hedman, M., Häggström, E., Mamhidir, A.-G., & Pöder, U. (2019). Caring in nursing homes to promote autonomy and participation. *Nursing Ethics*, *26*(1), 280–292. https://doi.org/10.1177/0969733017703698

Hirst, S., Penney, T., McNeill, S., Boscart, V., Podnieks, E., & Sinha, S. K. (2016). Best-practice guideline on the prevention of abuse and neglect of older adults. *Canadian Journal on Aging*, *35*(2), 242–260. https://doi.org/10.1017/S0714980816000209

Kangasniemi, M., Pakkanen, P., & Korhonen, A. (2015). Professional ethics in nursing: An integrative review. *Journal of Advanced Nursing*, *71*(8), 1744–1757. https://doi.org/10.1111/jan.12619

Klaassens, M., & Meijering, L. (2015). Experiences of home and institution in a secured nursing home ward in the Netherlands: A participatory intervention study. *Journal of Aging Studies*, *34*(3), 92–102. https://doi.org/10.1016/j.jaging.2015.05.002

Kor, P., Kwan, R., Liu, J., & Lai, C. (2018). Knowledge, practice, and attitude of nursing home staff toward the use of physical restraint: have they changed over time? *Journal of Nursing Scholarship*, *50*(5), 502–512. https://doi.org/10.1111/jnu.12415

Lohne, V., Høy, B., Lillestø, B., Sæteren, B., Heggestad, A., Aasgaard, T., Caspari, S., Rehnsfeldt, A., Råholm, M. B., Slettebø, Å., Lindwall, L., & Nåden, D. (2017). Fostering dignity in the care of nursing home

residents through slow caring. *Nursing Ethics*, *24*(7), 778–788. https://doi.org/10.1177/0969733015627297

Moller, A., Ryan, R., & Deci, E. (2006). Self-determination theory and public policy: Improving the quality of consumer decisions without using coercion. *Journal of Public Policy and Marketing*, *25*(1), 104–116. https://doi.org/10.1509/jppm.25.1.104

*Mullins, L., & Hartley, T. (2002). Residents' autonomy: Nursing home personnel's perceptions. *Journal of Gerontological Nursing*, *28*(2), 35–44. https://doi.org/10.3928/0098-9134-20020201-09

Murphy, K. (2007). Nurses' perceptions of quality and the factors that affect quality care for older people living in long-term care settings in Ireland. *Journal of Clinical Nursing*, *16*(5), 873–884. https://doi.org/10.1111/j.1365-2702.2006.01633.x

*Nikumaa, H., & Mäki-Petäjä-Leinonen, A. (2019). Counselling of people with dementia in legal matters–social and health care professionals' role. *European Journal of Social Work, Published*, *1–14*, https://doi.org/10.1080/13691457.2019.1568970

*Oakes, C., & Sheehan, N. (2012). Autonomy in assisted living: Employees' perspectives. *Journal of Housing for the Elderly*, *26*(4), 317–337. https://doi.org/10.1080/02763893.2011.649828

Olson, J., McAllister, C., Grinnell, L., Walters, K., & Appunn, F. (2016). Applying constant comparative method with multiple investigators and inter-coder reliability. *Qualitative Report*, *21*(1), 26–42.

Oosterveld-Vlug, M., de Vet, H., Pasman, H., van Gennip, I., Willems, D., & Onwuteaka-Philipsen, B. (2016). Which characteristics of nursing home residents relate to factors influencing their dignity? *Geriatric Nursing*, *37*(5), 365–370. https://doi.org/10.1016/j.gerinurse.2016.05.002

Oosterveld-Vlug, M., Pasman, H., Van Gennip, I., Willems, D., & Onwuteaka-Philipsen, B. (2013). Nursing home staff's views on residents' dignity: A qualitative interview study. *BMC Health Services Research*, *13*(1), https://doi.org/10.1186/1472-6963-13-353

Pluye, P., & Hong, Q. (2014). Combining the power of stories and the power of numbers: Mixed methods research and mixed studies reviews. *Annual Review of Public Health*, *35*(1), 29–45. https://doi.org/10.1146/annurev-publhealth-032013-182440

Poikkeus, T., Numminen, O., Suhonen, R., & Leino-Kilpi, H. (2014). A mixed-method systematic review: Support for ethical competence of nurses. *Journal of Advanced Nursing*, *70*(2), 256–271. https://doi.org/10.1111/jan.12213

Poikkeus, T., Suhonen, R., Katajisto, J., & Leino-Kilpi, H. (2020). Relationships between organizational and individual support, nurses' ethical competence, ethical safety, and work satisfaction. *Health Care Management Review*, *45*(1), 83–93. https://doi.org/10.1097/HMR.0000000000000195

Preshaw, D., Brazil, K., McLaughlin, D., & Frolic, A. (2016). Ethical issues experienced by healthcare workers in nursing homes: Literature review. *Nursing Ethics*, *23*(5), 490–506. https://doi.org/10.1177/0969733015576357

Reader, T., & Gillespie, A. (2013). Patient neglect in healthcare institutions: A systematic review and conceptual model. *BMC Health Services Research*, *13*(1), 1–15. https://doi.org/10.1186/1472-6963-13-156

Rejnö, Å., Ternestedt, B., Nordenfelt, L., Silfverberg, G., & Godskesen, T. (2020). Dignity at stake: Caring for persons with impaired autonomy. *Nursing Ethics*, *27*(1), 104–115. https://doi.org/10.1177/0969733019845128

*Ryden, M. B. (1985). Environmental support for autonomy in the institutionalized elderly. *Research in Nursing & Health*, *8*(4), 363–371. https://doi.org/10.1002/nur.4770080409

Scott, A., Harvey, C., Felzmann, H., Suhonen, R., Habermann, M., Halvorsen, K., Christiansen, K., Toffoli, L., & Papastavrou, E. (2019). Resource allocation and rationing in nursing care: A discussion paper. *Nursing Ethics*, *26*(5), 1528–1539. https://doi.org/10.1177/0969733018759831

*Scott, A., Välimäki, M., Leino-Kilpi, H., Dassen, T., Gasull, M., Lemonidou, C., & Arndt, M. (2003). Autonomy, privacy and informed consent 3: Elderly care perspective. *British Journal of Nursing*, *12*(3), 158–168. https://doi.org/10.12968/bjon.2003.12.3.158

*Scott, A., Välimäki, M., Leino-kilpi, H., Dassen, T., Gasull, M., Lemonidou, C., Arndt, M., Schopp, A., Suhonen, R., & Kaljonen, A. (2003). Perceptions of autonomy in the care of elderly people in five European countries. *Nursing Ethics*, *10*(1), 28–38. https://doi.org/10.1191/0969733003ne571oa

Sherwin, S., & Winsby, M. (2011). A relational perspective on autonomy for older adults residing in nursing homes. *Health Expectations*, *14*(2), 182–190. https://doi.org/10.1111/j.1369-7625.2010.00638.x

Sikorska-Simmons, E., & Wright, J. (2007). Determinants of resident autonomy in assisted living facilities: A review of the literature. *Care Management Journals*, *8*(4), 187–194. https://doi.org/10.1891/152109807782590646

*Solum, E. M., Slettebø, Å., & Hauge, S. (2008). Prevention of unethical actions in nursing homes. *Nursing Ethics*, *15*(4), 536–548. https://doi.org/10.1177/0969733008090524

Suhonen, R., Stolt, M., Habermann, M., Hjaltadottir, I., Vryonides, S., Tonnessen, S., Halvorssen, K., Harvey, C., Toffoli, L., & Scott, P. A. (2018). Ethical elements in priority setting in nursing care: A scoping review. *International Journal of Nursing Studies*, *88*, 25–42. https://doi.org/10.1016/j.ijnurstu.2018.08.006

*Taverna, M., Nguyen, C., Wright, R., Tysinger, J., & Sorenson, H. (2014). Iatro-compliance: An unintended consequence of excessive autonomy in long term care facilities. *Journal of Dental Hygiene*, *88*(1), 53–60.

*Tufford, F., Lowndes, R., Struthers, J., & Chivers, S. (2018). 'Call security': Locks, risk, privacy and autonomy in long-term residential care. *Ageing International*, *43*(1), 34–52. https://doi.org/10.1007/s12126-017-9289-3

Universal Declaration of Human Rights. (1948). *Xxxxx*.

*Van Thiel, G., & Van Delden, J. (1997). Dealing with patient autonomy in Dutch nursing homes. *Health Car in Later Life*, *2*(3), 177–186.

*Van Thiel, G., & Van Delden, J. (2001). The principle of respect for autonomy in the care of nursing home residents. *Nursing Ethics*, *8*(5), 419–431. https://doi.org/10.1177/096973300100800506

Welford, C., Murphy, K., Rodgers, V., & Frauenlob, T. (2012). Autonomy for older people in residential care: A selective literature review. *International Journal of Older People Nursing*, *7*(1), 65–69. https://doi.org/10.1111/j.1748-3743.2012.00311.x

Welford, C., Murphy, K., Wallace, M., & Casey, D. (2010). A concept analysis of autonomy for older people in residential care. *Journal of Clinical Nursing*, *19*(9–10), 1226–1235. https://doi.org/10.1111/j.1365-2702.2009.03185.x

Whitler, J. (1996). *Ethics of assisted autonomy in the nursing home: Types of assisting among long-term care nurses. *Nursing Ethics*, *3*(3), 224–235. https://doi.org/10.1177/096973309600300305

Whittemore, R., & Knafl, K. (2005). The integrative review: Update methodology. *Journal of Advanced Nursing*, *52*(3), 546–553. https://doi.org/10.1111/j.1365-2648.2005.03621.x

*Wikström, E., & Emilsson, U. (2014). Autonomy and control in everyday life in care of older people in nursing homes. *Journal of Housing for the Elderly*, *28*(1), 41–62. https://doi.org/10.1080/02763893.2013.858092

Zhai, X., & Qiu, R. (2007). Perceptions of long-term care, autonomy, and dignity, by residents, family and caregivers: The Beijing experience. *Journal of Medicine and Philosophy*, *32*(5), 425–445. https://doi.org/10.1080/03605310701631695

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