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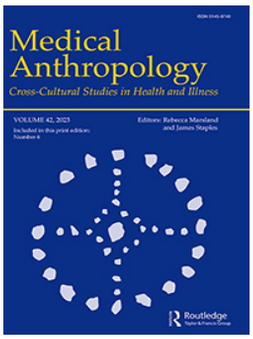
Published in:
Medical Anthropology

DOI (link to publication from Publisher):
10.1080/01459740.2023.2235066

Publication date:
2023

Document Version
Publisher's PDF, also known as Version of record



Routledge
Taylor & Francis Group

Medical Anthropology

Cross-Cultural Studies in Health and Illness

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/gmea20

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To cite this article: Emma Elisabeth Scully Jelstrup Balkin, Bente Martinsen, Ingjerd Gåre Kymre, Mette Geil Kollerup & Mette Grønkjær (2023) Temporalities of Aged Care: Time Scarcity, Care Time and Well-Being in Danish Nursing Homes, Medical Anthropology, 42:6, 551-564, DOI: 10.1080/01459740.2023.2235066

To link to this article: https://doi.org/10.1080/01459740.2023.2235066

Published online: 24 Jul 2023.

MEDICAL ANTHROPOLOGY
2023, VOL. 42, NO. 6, 551–564
https://doi.org/10.1080/01459740.2023.2235066

Temporalities of Aged Care: Time Scarcity, Care Time and Well-Being in Danish Nursing Homes

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ABSTRACT

Aged care staff in Danish nursing homes feel the pressures of time scarcity acutely. But what does this mean for the well-being of residents? Using the concept "care time" we consider subjective experiences of time to make sense of the multiplicity of temporal experiences in nursing home care. We will show how the temporal structures of a neoliberal institutional care logic is at odds with what residents expect from care time. Finally, drawing on a phenomenological understanding of well-being, we explore how residents' temporal orientation to the present and the past can be drawn on to enhance well-being.

KEYWORDS

Denmark; care; nursing homes; oldest old; temporality; well-being

"I don't have time for that," Doris said with a sour voice, mimicking the care staff in the nursing home, where she lives. Doris was quite upset that morning, as she recounted to me the latest incident where she had been told off by a staff member, something she said happens frequently. "I just don't understand why they have to talk to me so rudely," she said. Doris had asked for help with something that the carer did not see as a priority at that moment. It was around 8 am, a busy time of day in the nursing home, when care staff have a set list of tasks to tick off on their iPads as part of the morning routine.

Doris (all names are pseudonyms) is 87 and a retired nurse. "Never, in all my years in the hospital, would I have spoken to a patient like that," she told me. "You might be busy, but you always tell the patient nicely that you will make sure they get what they need." She looked at me with frustration, despondent that this was a recurring aspect of her nursing home experience. Doris had tried to raise the issue with staff but had been told that she just needed to understand that the staff are busy, busy, busy. "There is no time for extra demands."

This vignette is taken from ethnographic fieldwork conducted by the first author in two nursing homes in Denmark between June and December 2021, with a particular focus on well-being for the oldest old residents (defined variously in the gerontological literature as 80+ or 85+ years, see Kydd et al. 2020). It illustrates a common problematic, namely that staff are rushed and as a consequence, residents feel rejected. Over the course of my fieldwork (all of which will here be described in the first person), I spent many hours doing participant observation in the common areas of the nursing homes. Sometimes with residents, other times with staff. One of the most frequent topics of conversation was time, and I noticed that though everyone spoke of time and busyness, the *experience* of time and

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Media teaser: Everyone talks about a "lack of time" in the aged care sector, but what does this mean? How is time actually experienced in a nursing home?

busyness varied significantly for staff and residents. Staff would talk about never having enough time and residents would echo this discourse. When I asked residents about what sort of things made them feel good, their answers (chatting, going for a walk, sitting out in the garden, gentle exercise are some examples) would often be followed up with "but there isn't really time for that." I started to understand that time was central to the structure of the resident-carer relationship and began to pay close attention to the discourses around time in order to understand how it related to experiences of well-being in the nursing home.

Nursing homes have long been subject to ethnographic investigations of various kinds (for example, Diamond 1992; Gubrium 1975; Hazan 1992; Henderson and Vesperi 1995; McLean 2006; Rodriquez 2014; Savishinsky 1991; Shield 2018; Zhang 2023). As Twigg points out they make excellent sites for accessing older people's day-to-day experiences (Twigg 2005). This study contributes to a small, but growing, body of literature which seeks to understand the complex interrelation of temporality, care and well-being for older adults. Anthropologists have examined temporal aspects of aging in various ways, from Hazan's study of experiences of (dis)continuity in aging among older Jews in London (Hazan 1984) to more recent studies of the ways in which older people place themselves narratively in time. For example, Degnen found that older persons in the UK loop the past into the present, in a way that younger people typically do not, and which reinforces their stigmatized social position as "lost in the past" (Degnen 2005). In a similar vein, Elliott and Carpentieri have examined how older adults in Scotland narratively conceptualize their future selves, some invoking a past self as a way to guard against the fear of what a future (old) self might become (2020). In Finland, Heikkinen found that in very old age, the nearness to death created a sense of temporal unity, turning past, present and future into a whole (Heikkinen 2004). Recently, temporality has been studied as a framework for well-being for older people through gardening – both as a way of bringing continuity, by connecting the past with the present for older African-Americans in Detroit (Robbins and Seibel 2020); and as a form of temporal (Elliott and Carpentieri 2020) home-making, the cyclical nature of the seasons setting the pace for life post-retirement in the United Kingdom (Visser 2018). In ethnographic studies of dementia temporal dimensions have also been considered in relation to well-being. People living with dementia experience time as asynchronized, which poses challenges for social belonging (Glavind 2022), there is also little sense of a future. Gjødsbøl and Svendsen have shown how dementia care staff mitigate this by emphasizing the present moment – or "magic moments" – as a way of fostering well-being (Gjødsbøl and Svendsen 2019).

In this article we explore the multiple meanings of time in nursing home care, and how temporal modalities structure the possibilities for well-being for oldest old residents, moving between scales and using the concept of "care time" to consider how institutional structures impact the possibilities for everyday experiences. To do so, we draw on different bodies of literature on temporality. Starting at the system level we borrow from sociological insights on temporality and neoliberalism, we then turn to resident experiences of well-being, drawing on "dwelling-mobility," a phenomenologically based existential well-being theory developed by Galvin and Todres (2013).

Institutional logic and neoliberal temporality

The concept of time scarcity has become somewhat axiomatic in contemporary discourse. It is a premise that we accept as inevitable as the speed of life accelerates (Rosa 2013; Scheuerman 2005; Sugarman and Thrift 2020). Hartmut Rosa has written widely on the reasons why we feel this sense of time scarcity (2013, 2021). He poses that the temporal structures of modernity are characterized by a three-dimensional acceleration: technological acceleration, acceleration of social change and an acceleration of the pace of life (Rosa 2013). These three dimensions inextricably intertwine, causing us to feel a need "to perform a higher number of actions in an ever-shorter period of time" (Rosa 2021:31). In doing so we think we can "save time," but instead it is a self-propelling process that only serves to make us busier. With this comes a felt need to always keep moving in order to keep up, as well as the anxiety associated with slipping behind.

In care systems time scarcity is particularly problematic as health care personnel are under pressure to do more in less time (Bendix Andersen et al. 2018; Ihlebaek 2021; Thieme et al. 2022). New public management approaches, where business management models are imported into public institutions, are near-hegemonic across health care sectors as neoliberal policies wield their influence (Kamp and Hansen 2018; Krol and Lavoie 2014). These approaches manifest themselves in institutions in particular ways. Institutions operate under their own logic. Cloutier and Langley describe institutional logic as: "an ensemble of higher order meanings, values, norms and/or rules that frame how individuals make sense of the world around them and consequently know how to act. They reflect organizing principles that help frame collective action" (Cloutier and Langley 2013:361). The care provision system in Denmark, as elsewhere, is structured around a particular, neoliberal logic. Beyond an economic paradigm, neoliberalism operates as an "ideological configuration of ideas and practices" (Lynch and Grummell 2018), setting an "agenda of cultural and institutional change, extending – at least in potential – through every arena of social life" (Connell et al. 2009:333). Fundamentally, neoliberalism is changing the way we understand ourselves and each other. As Wendy Brown puts it "all spheres of existence are framed and measured by economic terms and metrics, even when those spheres are not directly monetized" (Brown 2015). In the health care sector this has meant that economic rationalities have taken priority over the production of health (Thieme et al. 2022). Nursing homes have been particularly constrained by this austerity (Diamond 1992, Henderson 1995; Rodriquez 2014) resulting in staff having to perform a "dance between a logic of care and a logic of cost" (Rodriquez 2014:4).

Privatization and deregulation are key tenets of neoliberalism. While aged care in Denmark is still largely a public responsibility, it is also the sector most affected by new public management reforms (Kamp and Hansen 2019). As the public sector is under pressure to align with a competitive market, neoliberal rationalities come to shape institutional practices. This is evident in the perpetual budget cuts to the aged care sector, with its concomitant focus on worker productivity and efficiency. For the purposes of this article, in which we aim to understand institutional temporal constraints on well-being, we will focus on the temporal aspects of neoliberalism, namely its focus on efficiency and its orientation toward the future, and the ways in which these aspects shape subjectivities (Sugarman and Thrift 2020; White 2020).

We use the term "care time" as a heuristic to reflect on the different meanings of time as it is experienced in the nursing home. Karen Davies was among the first to consider the meaning of time in care work and argued that there is a difference between *task time* and *process time* (Davies 1994). Process time is not experienced as linear or bounded. It is fluid and simultaneous. Davies says that task time "risks separating the activity, at least conceptually, from its context. Process time on the other hand emphasizes that *time is enmeshed in social relations"* (Davies 1994:280. Italics in original). The Danish language makes a distinction between *pleje* and *omsorg*. Pleje is the kind of care that is more medical and/or practical in nature, tending a wound, for example, or assisting with toileting. Pleje is task-oriented care. Omsorg, on the other hand, is a more affective kind of care; omsorg tunes into a person's emotional and existential needs and could be roughly translated as "compassion." What we will show here is that the institutional logics of the nursing homes primarily constitutes care in terms of pleje and staff therefore orient their work to task time, leaving little time for omsorg, despite this being both the institutional ethos and many staff's personal goal.

Method and context

This article springs from a larger project on well-being in institutional care relations among oldest old nursing home residents. It is based on ethnographic fieldwork carried out by the first author over the course of six months in 2021. The fieldwork took place at two nursing homes – Garden View and Oak Hill – in a larger Danish city. Both were publicly funded and under the direction of the same municipal authorities. Residents pay rent to live here but receive the care they need free of charge. Denmark has one of the highest tax rates in the world, and in return citizens expect the

state to care for them during times of need. Access to good, public aged care is thus considered a cornerstone of the Danish welfare state. At the same time, governments on both sides of the political spectrum have continued to scale back the funding for aged care over several decades. With a rapidly aging population and decreasing numbers of workers being attracted to an underpaid and undervalued care sector, nursing homes are under pressure and nearing crisis point. Recently, there has been increased public and political scrutiny of the sector and the seeds of reforms have been sown, but at the time of writing, the aged care minister is yet to propose the promised new legislation.

The residents at both Garden View and Oak Hill were almost exclusively ethnically Danish, there were approximately twice as many women as men, and most of those included in this study had had a rural childhood and had migrated to the city as young adults, in search of work. While most had experienced poverty in their childhoods, they had also benefitted from the improvements to standards of living after the second world war and had all ended up somewhere on the middleclass spectrum. None were university educated, as they came of age before universities were widely accessible. Instead, they worked in trades or as farmers, the women more often as cooks, bakers, nurses or housewives. Two were artists. All had been married and most had lost their spouses. Many, but not all, had children. All interlocutors were aged 84 and over. It bears mentioning that though I had lived overseas for most of my adult life, I did in fact grow up in this city. As such, I could draw on my own childhood and memories of how this town used to be – heavily industrial – to relate to my interlocutors.

Both nursing homes are organized around smaller units with 12–15 residents in each. I primarily spent time in three of these units. During my time there, I involved myself in the everyday life of the nursing home, participating in activities, excursions and mealtimes, visiting residents in their rooms – privacy is highly valued in Denmark, and each resident has their own room with bathroom and kitchenette – and spending time with residents and staff in the common areas. I helped out where I could, setting the table, serving meals, emptying the dishwasher and folding the laundry.

Sandwiched between two COVID-19 lockdown periods, the fieldwork was carried out consecutively, and the research at the second nursing home was unfortunately cut short by COVID-19 restrictions. Other than the limitations to the duration of the project, the impacts of COVID-19 on the fieldwork were relatively minimal. While mask-wearing was required at the beginning, this restriction was removed within the first few weeks of my time in the field. Residents were allowed to gather, eat together and participate in activities again. This meant that I could also move freely in the nursing home.

The staff in both nursing homes were also largely of ethnic Danish background, though this was shifting, especially among newer staff, who more often had non-European backgrounds. The staff were largely, though not exclusively, female, and most had a formal qualification as nurse assistants.

I conducted 10 interviews with residents, but it became evident that gaining the desired depth of data this way was a challenge. It was difficult for most interlocutors to reflect on their own nursing home experiences in an interview format. None of my interlocutors were diagnosed with dementia, but mild cognitive decline was present for some. Often, they assumed I was conducting a quality assessment of the nursing home facility – "the food here is excellent" was a common refrain. Or they thought that I was there to learn about "the olden days," sometimes mistaking me for a high school student (their estimation of my age out by several decades!). Pols argues that the interview as a method to gain knowledge about the participant's experiences presupposes a particular kind of subject (2005). While I had intended to conduct more interviews, it quickly became clear that I had overestimated their yield. My attention shifted from foregrounding the voices of the oldest old to the way everyday life unfolded in the communal spaces of the nursing home. Participant observation and informal conversations therefore became the preferred method. It was often in the in-between moments of everyday life, such as when pushing along a resident in a wheelchair or when helping get ready for an activity that the little gold nuggets of insights into their experiences appeared.

Temporal regimes in the nursing home

One morning Aksel, a resident, and I were having coffee in the dining room, when Asta came out and joined us. The three of us would often have coffee together in the mornings, while Aksel flicked through his newspaper. Today Asta looked weary. It was her shower day, a weekly event that she finds exhausting. "She is always in such a hurry," Asta said, about the staff member that assisted her. "It has to happen so fast, and I'm not able for that. How would she like to be rushed like that when she is 100 years old?" Here Asta gestures at the different temporal needs of residents and staff. For Asta, a shower is an ordeal that requires all her energy. She will be tired for the rest of the day after a shower. But the staff member had to hurry because she had other tasks to attend to. Staff often rush in order to manage all the tasks on their lists. Being busy is colloquially referred to as *running fast*, an expression imbued with a sense of franticness. Efficient time management is a key requirement in the working day, but can leave residents feeling objectified.

Time operates as the fundamental organizing principle in Danish nursing homes. It is what structures the rhythm of the day, and the interactions of staff and residents. This institutional logic sees time as a resource that can be saved, optimized or wasted. This means doing more things, faster (Rosa 2013; Sugarman and Thrift 2020). It also means that we lose our patience for pursuits that are inherently slow (Scheuerman 2005). It is a task-oriented logic, and the efficiency of task performance is measured in metric time. Time is both a measurement of efficiency, an indicator of performance, and a commodity that can be bought, sold and traded (Henderson 1995; Rodriquez 2014). Under this logic, time is considered such a scarce resource that a system has been devised in which residents are given time vouchers – 24 minutes per week to be exact – that can be used to buy the extra care services they desire. These so-called "extras" include things like having your hair done, or your beard shaved; getting help to tidy up a cupboard or going outside for a stroll in the sun. It can be used to have a staff member accompany you on a hospital visit. It is also possible to save up vouchers for a longer stretch of extra care. Some staff actively resist this system and perform "extra" care without registering it in the voucher system. "I have some residents who can shave themselves no problem. Others have the shakes or can't see well" Lene, a long-time staff member, told me, demonstrating that in practice it can be really difficult to draw the line between basic care and extra care.

The voucher system is intended to introduce more choice and agency into the care relationship, however for most nursing home residents it is too difficult to understand, and often the staff end up administering the vouchers, without consulting the residents. Helena, for example, was a 90-year-old resident, who did not like to socialize with other residents, and rarely left her room. It was deemed necessary that she have more social contact. So, the management decided to send in a particular staff member to visit her each week for a chat. Helena's 24-minute voucher was used for this purpose, though the visits often did not last more than 15 minutes. This staff member was not trying to cheat Helena out of minutes. But he refused to translate care into minutes. He spent the length of time he felt was needed to give omsorg, and if someone else was in need that day, then he would go and see them too. This is the kind of "tinkering" (Mol et al. 2010) that care work requires. Because good care cannot be "contained by or measured within the categories of productive time and value" (White 2020).

Under this institutional logic care is a set of tasks, which is turned into a commodity. Care time in this logic is quantitative, not qualitative in nature. Care staff come to think of their work as being primarily about pleje, because pleje is the kind of care that can be meted out into discrete tasks, ordered on a list and completed. It imbues the work of care with a chronology that renders it apt for optimization. Omsorg in this regime becomes an extra to fit in "when there is time." But as Hanne, a long-time staff member with a kind demeanor, told me: "I just never have time for the psycho-social stuff, even though it's so important." This chimes with Tronto's assertion that "the usual view that arises from thinking of care as a commodity is to see any increase in caring time as a cut in time for another activity" (2013:164).

Time scarcity and time work

For staff, time is a resource in short supply. They told me almost daily that they do not have enough time. There is barely enough of it to complete all of the tasks on their schedule, much less to do the "extras" that they feel would make life a little nicer for residents. Much of the time, staff have their eye on the clock. Institutional routines train them to always keep an eye on the time. Tasks often need to be completed quickly in order to move on to the next task. There is also a fairness principle, impelling staff to not spend too much time with one resident, lest others be neglected. Every time a staff member enters a resident's room, they press a button – a so-called "presence button" - which times how long they are there for. That way time spent with residents can be documented down to the second. Lene explained to me that they use this documentation in case a resident's next-of-kin takes issue with the care that the resident is receiving – "if that happens, we can hand them the log and prove exactly how much time we've spent in the resident's room," she said, equating minutes to care. Lene feels torn about the requirement to document minute details of care: "if we could get away with only doing half of the documentation we do, then we'd have more time to spend with residents. But it also covers our backs, so . . . " The requirement to document is embedded in an institutional logic that conceptualizes care as something measurable. As a praxis excessive documentation renders certain aspects of care (pleje) visible, while obscuring others (omsorg). As Kamp and Hansen point out: "When something is systematically monitored, something else is systematically overlooked" (Kamp and Hansen 2018:231).

Oftentimes staff members also informally keep tabs on each other, commenting that they have spent too long on something, or joking about where they have been hiding, and why they are slacking off. Time keeps everyone accountable. It also acts as a buffer for critique – a lack of time is a valid explanation for jobs half-done, or for turning down requests for help. "They always say 'I'll come when I have time,' but I need them now" Ida, a 92-year-old, told me. Ida was often confused, and her needs typically centered around reassurance, but many of the staff would quickly get frustrated with her, feeling that she was taking them away from other tasks that they ought to be doing. As a result, Ida was often ignored by staff.

For all that time is a scarce resource for staff, it is also a ruler. As shift workers, staff adhered strictly to rosters. Towards the end of the shift, time was suddenly ample, slow even. The last hour or two of the day shift tended to drag out. I would often sit with staff as they tried to while away this time. Once the residents had retreated to their rooms after lunch, a few practical or paperwork chores were attended to, often followed by an extended period of downtime. During this time, I noticed a paradox: that while we were sitting around, waiting for the shift to end, staff would complain to me that they really wished they had more time to do things with residents, to provide psycho-social care or to just hang out with them. At the same time, we watched the clock, counting the minutes until they could go home. This clock watching was a shared activity, what Flaherty calls "time work:" a deliberate exercise to make the passing of time feel faster (Flaherty 2010). Every now and then someone would announce "only 20 more minutes now!." "This time is the longest part of the day" Jette, an experienced staff member, explained. Isabella, a 19-year-old summer substitute, who held no formal qualifications and had only been working in the nursing home for a couple of weeks, echoed this sentiment, as she lay slumped on the couch. Staff would give words of encouragement to get each other through this boring time. They talked about what they would do when they "get out of here." Those whose shifts did not finish until 3 pm expressed envy that they would not be "let out" just yet. And those who had the day off tomorrow made sure to announce it joyfully to all. "Thank God I don't have to be here tomorrow," Kimberly said during a staff break one day. Talk of time off was one of the most frequent topics of conversation that I observed amongst staff. I have noted it in my fieldnotes almost daily.

We can unpack this paradox in several ways. The spatiotemporal orientation away from the nursing home may be a sign that staff value their personal lives over their work lives. It could also be a sign that they are not fully satisfied with their working environment. A third possibility is that this downtime is an act of resistance to a system, which squeezes the life out of them. One staff member often complained that the demands of the work "sucks all the energy out of me." From this perspective,

sitting around being unproductive while on the clock is a way to resist the pressures for constant productivity and assert ownership over their own time (Flaherty 2010). While we think all three of these factors play a role, we argue more significantly that the paradox arises from the entrenched task-oriented approach to care. Because the neoliberal care regime values completable tasks, which can be broken down into measurable units, these practical and medical tasks become analogous with care time for staff, as they lend themselves to the logic of productivity. Care time as omsorg comes then to have a nebulous character, because where does it start and where does it end? Davies proposed the concept of *process time* precisely because caregiving can be so fluid in nature, without an obvious start or end it is looping in nature (Davies 1994). Omsorg requires a mental shift from future orientation to present-centeredness. Lennart Fredriksson (1999) distinguishes between two different kinds of nursing presence: *Being there* and *being with*. Being there entails the nurse attending to the patient's needs, similar to pleje. The structure of being there is that of "question and answer" in the sense that the patient has a need and the nurse a response.

In contrast, being with is grounded in reciprocity. The structure of being with is that of "gift and invitation." In this way of being present the nurse offers their whole self, and if the patient accepts this gift, they reciprocate with an invitation to enter into their vulnerability. In this kind of presence, "nurse and patient are not only present to each other as roles, but in addition are present as whole persons" (Fredriksson 1999:1171). According to Fredriksson, being there helps patients (residents) cope, while being with alleviates suffering and loneliness and allows for growth through difficult experiences. This is a more extensive concept of care than what is commonly thought of as omsorg, but the presence of mind required and the more affective nature of being with care is also captured in omsorg.

The institutional logic trains staff to think of care time in terms of task-oriented being there care. This is the primary remit of a care worker. Being there care is the kind that can be sectioned into discrete tasks and counted in minutes. While being with care is of a different nature. It cannot be measured in units of time. It therefore is at odds with the logic of institutional care. It is not that staff are not aware of the psycho-social elements of care – as that of being with care – but they see it as an extra, something to do if there is time. The parsing of care into discrete, manageable tasks and more amorphous "extra" can lead to a sense of the extra being too difficult to fit in, because it cannot be delimited as a task. Julie Anne White calls this kind of care "excessive" because it defies the categories of productivity and economic value (White 2020). Henderson similarly pointed to a "cult of time and task," in which the occupation with basic care blinded care staff to the importance of psychosocial care (1995).

One day, I was introduced to Mona, a staffer I had not met before. She was sitting at the staff table in the common room, chatting with the other staff members. In between chatting, Mona yawned and counted the minutes. I asked if it was a slow day today and she told me that she was just here to make up time. She had been on a three-hour training course the previous week, but because the minimum shift is five hours, she now had two hours to make up. "And of course, they won't just give it to her," said Camilla, the "they" referring to management. An us-them distinction was often drawn very sharply, when talk fell on management. "So, now I'm just sitting here, willing the time to pass," Mona said with a shrug. Arguably, Mona had two hours that she could have spent doing the "extra" things with residents. But for many staff, the extra defies the institutional logic so embedded in their care practice. Outside the set list of tasks, the extra comes to be associated with extra work, as in *more* work. Some staff therefore avoid it, because that would be giving management something for free. Feelings of animosity toward management, then, manifest in a tick-the-box attitude toward one's work.

This attitude was not shared by all staff of course. On the whole, staff talked about their work as something that matters. They had chosen this path because they wanted to "do something good for the old people." For many, busyness is symbolic of virtue (Ekerdt 1986). The institutional logic of neoliberal temporality creates a culture, whereby the feeling – and performance – of being rushed signals that you are doing the job right. There is prestige in that, as it makes you one of the team. There is solidarity in feeling busy. Some staff manage to weave omsorg into their busyness, seamlessly combining task and process time (Davies 1994). Maria, a senior staff member, put a lot of effort into –

and derived a lot of satisfaction from – seeing beyond residents' behaviors to try and understand the need behind the behavior. She even spent her free time thinking about how she could "crack the tough nuts," meaning how she could adapt herself in order to improve her relation with a difficult resident, and thus make them more at ease in the nursing home.

When staff talk of time, it is thus not always an accurate representation of how much clock time they have available. Instead, talk of time scarcity is a cultural script (Fairclough 2001). These scripts are normative narratives that reproduce particular understandings of time. It is a way for staff members to signal to each other that they belong there, that they are good at their jobs, that their jobs are often demanding, and that they matter even though they are undervalued. Being busy is a neoliberal virtue. Isabella, the summer substitute, shows how quickly these scripts are adopted as the normative discourse among staff. In her attempt to fit in and demonstrate to me, and the other staff members, that she belonged here, she assimilated to – or at least performed assimilation to – the institutional logic.

Dwelling-mobility and bringing the past into the present

We have described how staff experience time as both a scarce resource and a punishing regime. We now turn to the resident experience of time in the nursing home. Drawing on phenomenological well-being theory (Galvin and Todres 2013) we consider the pertinent temporal horizons of residents. For residents time is at once scarce and ample. In very old age their "days are numbered," as they like to tell me, evocative of the title of Myerhoff's seminal book *Number Our Days* (1978). And much like for Myerhoff's interlocutors the future is tomorrow and maybe next week. There is not much time left on this earth. Many of them told me that life had nothing left in store for them. "I never asked to get so old" Asta, 101, said, "I'm tired. I am not owed anything [by life]." The future as a temporal horizon is meaningless to many, though not all, of my interlocutors. The more relevant temporal tense is the present. But the present is an amorphous thing. The days in the nursing home often feel long and drawn out. Doris spent her days sitting on a chair in one of the hallways, trying to catch glimpses of the life happening around her.

For residents the present moment is given shape by care time. Care time punctuates the long, boring days. Care time is a highlight, it gives meaning to the day. Helen, 88, found the nursing home a lonely experience. "The evenings can be very long. And the staff don't have time to come and be with you. Even if you go out into the common room, they just sit there watching tv. They're not motivated for it." By "it" Helen meant spending time engaging with residents. "It's so nice, though, when they [staff] do take five or ten minutes to come and have a chat. It's *hyggelig* [cosy and convivial] ... it makes you feel like you matter." With this sentence Helen sums up just how much value many residents find in a few moments of attentive omsorg. For residents care time is not measured in metric time, rather it is the feeling of being seen, heard and valued (Balkin et al. 2023). Care time from this vantage point is fundamentally relational. It is being with care (Fredriksson 1999). The present moment therefore holds potential for fostering well-being.

In their theory of dwelling-mobility, Galvin and Todres (2013), inspired by Heidegger's concept of *gegnet*, theorize well-being as a sense of being at home with what is given (dwelling) combined with a sense of being called into new horizons (mobility). It is an acceptance of one's current situation, what Heidegger calls *gelassenheit*, while also having a sense of having something more in store. Dwelling-mobility is manifested within six different dimensions, namely: Spatial, temporal, intersubjectivity, mood, identity and embodiment. These dimensions overlap and intertwine, but for the purposes of this article, we focus on the temporal dimension. Temporal dwelling-mobility is a combination of present-centeredness (dwelling) and future orientation (mobility), together they combine in a well-being experience that Galvin and Todres call *renewal*. Here, a person experiences a simultaneous sense of being "absorbed in the present moment" with the "novelty of being called into the newness of the future" (Galvin and Todres 2013:84). In contrast – and noting that well-being and suffering exist on a continuum – the suffering experience of dwelling-mobility is a sense of having "no respite," with

a "blocked future" (mobility) and an "elusive present" (dwelling). Drawing on this theory we will now explore the temporal experiences of nursing home residents.

For residents, temporal orientation is primarily present-centered and retrospective. There is little sense of a future beyond the immediateness of tomorrow and maybe next week for many of my interlocutors. For some this was difficult to come to terms with, while others seemed more at peace with the finitude. It was generally the older of my interlocutors, those in their 90s, who expressed a sense of acceptance, or *gelassenheit*. Agnes was 96 and told me that her family expect her to live to 100. She herself was more tentative: "we just have to see what happens." For her, getting out of bed in the mornings and having some nice moments during the day was more meaningful than thinking about the future. Asta, at 101, would occasionally say to me that she was "sated with days," meaning literally that she had enough time, she had no desire for anymore. Jens, on the other hand, at 84 years of age had much more anxiety about the passing of time. He also struggled with what the future might hold, worrying what would happen if he were to get dementia. "I don't want to change. I am who I am" he said, explaining further that he hopes he would still be treated as the same person, even if his personality were to change. This experience that the future has nothing good in store is what Galvin and Todres call a "blocked future" (Galvin and Todres 2013). Galvin and Todres suggest that a remedy for a sense of blocked future can be for carers to invite the suffering person into a meaningful future by giving them something to look forward to. Jens did enjoy being included in activities at the nursing home but was increasingly withdrawing from social occasions as his disease progressed, causing him to be embarrassed around others. He spent much of his time in an "elusive present" (Galvin and Todres 2013). Unable to find peace, he passed his days, sitting in his armchair, trying to piece together the fragmented memories of a difficult past. "There's nothing good about getting old," he told me. Heikkinen similarly found that interlocutors in their eighties were more aware of the passing of time, and more concerned about life's finitude than they were when they reached their nineties (Heikkinen 2004).

Galvin and Todres' theory holds that mobility in the temporal dimension is future oriented. But for some of my interlocutors the past also holds a possibility for mobility. This happens when the past is revisited in the subjunctive mode, the "what-if" mode. In this mode the past has a sense of imagined potentiality. Ebba, for example, would sometimes wonder what would have happened if her father had let her get an education. She was good at school and the teacher saw a bright future for her. But she was one of 8 siblings and her father had categorically denied her the possibility of continuing past year 7. He could not afford it, and she was needed on the farm. This had been a sliding doors moment early in her life, which continued to haunt her throughout her life. What if she had been allowed to get an education? Ebba was no longer angry with her father, she had accepted his decision long ago, and was overall pleased with the way her life had turned out. But the smart bookish child inside her still dreamed of what that future might have looked like. And so, at 95, Ebba would sit in her comfortable chair in her nursing home room and dream of what might have been. These armchair excursions gave her that sense of mobility that the future no longer could. In this way the past can also hold the prospect of new horizons, not as a realistic opportunity of the future, but as a speculative potentiality of the past. This kind of rumination is different to regret. It does not hold one stuck in painful events of the past, thereby causing an "elusive present". Instead, it opens up a temporal pocket, where one's past self still has an imagined future. And it is this experience of, albeit imagined, possibility that holds potential for the experience of well-being in very old age.

Another way in which the past holds potential for moments of well-being, is by bringing it into the present through narrative. For some of my interlocutors, like Jens, the past held many painful events that still needed to be processed. For them, talking about the past was a way of trying to make sense of these events. For others, being given the chance to narrate their life story was a way of holding on to their identity, of bringing their past self into the present. Anna for example, at 88, was new to the nursing home, and it was important for her to talk about the job she had held before retiring. Having overcome obstacles of poverty, and societal norms around women's place being in the home, Anna had trained and subsequently worked as a guidance counselor. She was proud of this achievement and

reflecting back on it imbued her life in the present with meaning. Martin, 94, told me that he enjoys spending much of his time just looking back over a life that he feels has been very rich and rewarding. Simone de Beauvoir calls this an "intimate solidarity with the past" (De Beauvoir 1996:362).

Some residents had no relatives left. Margaret was a 96-year-old woman; her son, husband and seven siblings had all passed away. She felt an acute sense of loneliness in the world. To her, recounting the past was a way of keeping her loved ones alive in the present. Margaret and I would sit together for hours as she told me about her family and their life together. I realized that in these conversations, Margaret was not simply telling me about the past. She was reliving it, imaginatively placing herself back in that time. She would talk about things as though they had just happened last week, and only later would I realize that it had happened decades ago. In this way Margaret erased the distinction between distal and proximal spheres of experience, collapsing them into one and the same. Degnen describes how this narrative style of older adults has a stigmatizing effect because younger people perceive it to be incoherent; a sign of the older person being stuck in the past (Degnen 2005). Staff members would tell me that Margaret was a little confused, and in a linear chronology perhaps that was true. But it was more meaningful than mere confusion, or being stuck in the past; it seemed to be a way of tethering herself to a time when Margaret felt like herself, a person in relation to persons to whom she mattered, and who mattered to her.

Thus, talk of the past serves many different purposes for oldest old nursing home residents. What they all reveal is that being given time to dwell on the past holds the potential to enhance well-being. But within neoliberal institutional logics, which are steadfastly forward focused (White 2020), dwelling on the past is considered unproductive. When the past is brought into care time it is often is small snippets. For example, when Aksel took his morning coffee in the common room, Jette, a very friendly staff member, would sometimes ask him about cars as she tended her chores nearby. Aksel used to be a mechanic, and Jette knew that talking about cars would instantly make him light up. Staff would often make reference to these snippets of a resident's past in order to bring their past identities into the present. But deeper engagement with the past would often be dismissed as unnecessary or too time-consuming.

The meaning of the soon-to-be-forgotten present

The other temporal mode that is meaningful to residents is the present. This is evident in several ways. There is an acute awareness of needs in the present moment – a need for the toilet, a pain in one's leg, and so on. Needs that announce themselves with urgency in the here-and-now. Such physical needs command attention, both the residents' and the staff's, and are usually dealt with promptly. This is the question-answer kind of being-there care (Fredriksson 1999). The other aspect of the present-centered mode is more contentious in the nursing home. This centers on how important it is to provide positive experiences in the present moment that cannot be remembered in the near future moment.

At Garden View this was expressed in a conflict over the value of activities for the residents. Some staff felt that activities were crucial to providing a meaningful everyday life for the residents. Others felt that activities were pointless because most residents only had limited capacity to participate, and many had limited or no memory of it afterward. Therefore, they reasoned that it was better for the residents to rest than to participate (however limitedly) in these activities. This reveals a temporal assumption that aligns with a utilitarian institutional logic: that for residents to benefit from an activity they should be able to actively recall it afterward. My experiences, however, point in a different direction.

Each week Mark, the activity coordinator at Garden View, facilitated a chair-gymnastics session for the residents who want to participate. I participated in many of these sessions and the exercises were usually the same. With around 15 participants, we would sit in a circle and the atmosphere was very convivial. Residents were typically quiet, maybe even withdrawn, when they arrived in the room, but as the exercises got under way they would soon loosen up and become more outgoing. One of the games was simply bouncing a soft ball across the floor to a person on the opposite side of the circle, which involved making eye contact to establish cooperation. This very simple game created connections between residents that were anchored in sharing this present moment. In this circle, on

a Monday morning, the residents were a part of something *together*. In this way the temporal and spatial dimensions framed an intersubjective space, which, supported by Mark, allowed the residents to feel a sense of belonging. This activity demanded very little of residents, they were seated, you only talked if you wanted to, but in this circle, everybody was included. And the mood here was light and happy and distinctly different to any other time in the nursing home.

Yvonne participated actively in these sessions. At 96, she was still very agile and the only one able to direct the balloon into the net Mark would place in the middle of the circle. She would get it every time and enjoyed showing off while doing it. But after leaving the room, Yvonne would be unable to verbalize any recollection of the activity. Some of the care staff therefore thought her participation was pointless. And yet, Yvonne turned up every week, eager to participate. This suggests that even though she could not talk about the activity afterward, it nonetheless left her with a sense of well-being. The present moment has intrinsic value regardless of its imminent erasure from memory. The importance of the present moment is also highlighted in the literature on dementia, where the exclusive orientation to the present may even heighten the experience of well-being (Chatterji 2006; Driessen 2018; Gjødsbøl and Svendsen 2019). However, under a logic in which time is something to be rationed, activities are not seen as an integral part of everyday life, but an optional extra that can be excised.

Making sense of multiple temporalities in aged care: Concluding remarks

Care staff operate within the confines of systemic time, which is perceived as both scarce and oppressive. But staff also exert temporal agency, stretching out breaktime, or enacting busyness as a virtue. The meaning of time scarcity is negotiated in context. Talk of time is so woven into the fabric of everyday life in the nursing home that residents also reproduce this narrative. The doxa of time scarcity shapes the caring relationship. Because residents know that care staff do not have enough time, some respond by a form of caregiving in their own right – by reducing demands, by waiting to ask for what one needs, by going without, and by gauging the care worker's emotional state before approaching them. Many residents strive to become the "good patient" that does not impinge too much on staff's time, demonstrating that caregiver and care-receiver are not the stable categories that the institutional logic would have us believe. Furthermore, this logic produces particular subjectivities, in which staff are those who do *not have time* and residents are the ones who do *have time*. Arguably, from a clock time perspective, residents are the ones with precious little time. But a large part of a resident's day revolves around waiting. There is an explicit expectation for residents to be patient, and when they are not, it causes frustration among staff. This raises questions about whether the care system is implicitly ageist, valuing one generation's time over another's.

The neoliberal logic that reduces care work to productivity is fundamentally at odds with the nature of relational care work that happens in omsorg and *being with* care. Constant optimization is not achievable in care work, where "an important aspect of care is simply spending time with another, listening to stories, observing care receivers" (Tronto 2013:121). Care, then, to some degree equates to time itself. It is not possible to give care without giving time. While care tasks can hypothetically be accelerated, both executed more speedily and in faster succession, the outcome is anything but caring, as both Doris' and Asta's experiences exemplify. White also operates with a *care time* terminology. She argues that care time is dyssynchronous with dominant neoliberal temporal regimes. Instead, we need to acknowledge that care time is slow time, and it must be reclaimed, so that it is not subsumed into a neoliberal regime in which time is commodified and the value of care work reduced to "productive efficiencies" (White 2020:163).

In this article we have explored multiple dimensions of temporality in Danish nursing home care. We have shown that there is a discrepancy in experiences of care time. Everyone, staff and residents alike, speak of staff time as a scarce resource. But it is arguably not metric time per se that is in short supply. While clock time may sometimes be tight, it is more that the *perception* of time is encoded with meaning through a particular discourse – and praxis – of time. Time scarcity is invoked as a way of expressing the work pressure that staff experience. Caught between the constant systemic demand to optimize time usage on the one hand, and the residents' pleas for slower and more present care on the other, staff members are in a difficult position.

Using different theoretical frames, we have mapped the micro-experience(s) of resident well-being onto the more macro-structures of the care system. In moving between scales, we have shown how the institutional logic and temporal regimes of the institution set the parameters for the kinds of well-being experiences that are possible for residents. At the same time, residents are also actively creating their own possibilities for temporal well-being. By immersing themselves in past moments it is possible for residents to experience a sense of agency and empowerment. This can be a diversion from the realities of the present moment, being at the mercy of staff's limited time, the loss of bodily functions, and the realities of institutional living. But under supportive conditions the present moment can also be a modality for well-being. Galvin and Todres describe this present-centeredness as "anything that offers absorption as a moment of welcome 'being here'" (Galvin and Todres 2013:84). This kind of well-being experience is therefore also spatial, which Galvin and Todres describe as a sense of "at-homeness."

Future work should explore how resident well-being and staff well-being intertwine as these are undeniably two sides of the same coin (Rodriquez 2014). We have touched on the tensions between staff and management, and staff's spatiotemporal orientation away from the nursing home. Addressing this disconnect could increase mutual well-being by making the nursing home somewhere that staff *want* to be, and where care time is a reciprocal experience of well-being and sense of "at-homeness" for both residents and staff.

Acknowledgments

The authors would like to thank Jayme Tauzer and the anonymous reviewers for their constructive feedback and advice.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

This project has received funding from the European Union's H2020 Research and Innovation Programme under the MSCA-ITN-2018 under grant agreement No 813928. The financial sponsor played no role in the design, execution or analysis of data, nor in the writing of this article.

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