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Preserving Everyday Identity during Institutional End-of-Life Care: A Conceptual Model of Personal Rituals, Familiar Objects, and Negotiated Nursing Routines for Person-Centered Practice

Carmen Ruiz[1]*, Javier Morales[2], Lucía Ferrer[3]

[1]*Department of Nursing, University of Barcelona, Barcelona, Spain.*
[2]*Department of Palliative Care, University of Valencia, Valencia, Spain.*
[3]*Department of Nursing, University of Seville, Seville, Spain.*

Abstract

To examine how everyday identity may be preserved during institutional end-of-life care through personally meaningful rituals, familiar objects, relational continuity, and negotiated nursing routines, while accounting for changing preferences and organizational constraints. Discursive conceptual paper based on a critically selected body of nursing, gerontological, dementia-care, palliative-care, and person-centred-care scholarship. Peer-reviewed literature published between 2017 and 2024 was selected to illuminate everyday preferences, material environments, autonomy, dignity, family involvement, nursing routines, communication, and institutional feasibility. Evidence was interpreted as a conceptual rather than systematic-review corpus; no review-selection counts or pooled claims were generated for this paper. Institutional care can support safety, symptom management, continuity of professional care, and relational support while simultaneously limiting the resident's control over time, objects, relationships, and ordinary practices. Preserving identity therefore cannot be reduced to reproducing previous routines or documenting preferences. The proposed Everyday Identity Preservation Model treats identity-supportive care as a conditional process of recognition, negotiation, and continuity. Recognition concerns what currently carries meaning for the person; negotiation addresses tensions among resident preferences, clinical needs, family involvement, and institutional feasibility; continuity concerns sustaining or adapting meaningful practices without treating them as fixed. Everyday identity can remain a legitimate concern of end-of-life nursing when personal rituals, objects, relationships, and temporal preferences are treated as potentially meaningful but revisable aspects of care. Their preservation requires individualized interpretation rather than standardized replication.

Keywords: Nursing, Person-centered care, End-of-life care, Nursing homes, Identity, Patient preferences

Introduction

Institutional end-of-life care inevitably reorganizes everyday life. Meals, bathing, medication, sleep, visiting, symptom assessment, documentation, staffing transitions, and safety procedures become coordinated within systems designed to care for many people simultaneously. These structures may provide essential continuity and protection, yet they can also narrow the resident's practical control over the small choices through which identity is ordinarily enacted. Qualitative research in care homes shows that identity is shaped within relationships, routines, available resources, and opportunities for autonomy rather than existing separately from the institutional environment [1]. The central problem is therefore not simply whether an institution knows a person's biography, but whether the person can continue to inhabit recognizable forms of everyday life as illness progresses.

For residents with dementia and other forms of dependency, a sense of home may be supported by familiar surroundings, personal possessions, meaningful activities, relationships, privacy, and safety, while institutional

Corresponding author: Carmen Ruiz
Address: Department of Nursing, University of Barcelona, Barcelona, Spain.
E-mail: ✉ carmen.ruiz@ub.edu
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features can remain simultaneously present [2]. This coexistence matters at the end of life. Familiarity should not be romanticized as the recreation of a previous household, because institutional care has different clinical responsibilities and material constraints. Yet the ability to recognize one's room, encounter meaningful possessions, interact with familiar people, or follow an individually valued rhythm can influence whether care feels personally continuous or externally imposed.

Material familiarity also extends beyond decorative personalization. Ethnographic work examining object-person relationships in dementia care has shown that functional and personally meaningful objects can contribute to identity, participation, and practical citizenship, while institutional control over access to objects may limit those possibilities [3]. An item therefore matters not because it is intrinsically therapeutic but because of how it participates in a resident's current practices and relationships. A photograph may invite recognition, a radio may sustain a valued evening practice, familiar clothing may support self-presentation, and a personal chair may organize comfort or social interaction. The same object may have little meaning for another resident or may become burdensome as sensory, cognitive, or clinical circumstances change.

Everyday preference is similarly important because person-centred care is enacted through choices that may appear minor to institutions but consequential to residents. Nursing-home research has reported a positive association between residents' perceived choice over everyday preferences and satisfaction with care [4]. Such findings do not demonstrate that preference fulfilment causes better clinical outcomes. They do, however, support the proposition that ordinary choice is part of how residents experience care and exercise agency within environments where much of daily life is coordinated by others.

Preferences must also be treated as conditional rather than frozen representations of identity. Longitudinal investigation of nursing-home residents' social-contact preferences has shown that their importance may depend on circumstances, interpersonal quality, and practical barriers [5]. A preference recorded earlier may remain important, become less important, or require a different form of enactment as illness, fatigue, symptom burden, relationships, or cognition change. Preserving identity consequently requires attentiveness to continuity without turning continuity into compulsory sameness. This distinction is especially important in end-of-life care, where a person's capacities and priorities may change quickly.

The argument developed here begins from that tension. Institutional nursing must accommodate clinical safety, collective organization, staff workload, family relationships, and unequal resources while remaining attentive to the resident's own experience of meaningful everyday life. The conceptual task is to explain how personal rituals, familiar objects, relationship patterns, and temporal preferences might remain visible within those competing demands without assuming that every resident wants continuity in the same form. The Everyday Identity Preservation Model therefore treats identity not as a checklist of biographical facts but as something expressed through selectively meaningful and revisable practices.

Background

Person-centred care provides an important foundation for this argument, but preference recognition alone does not explain how everyday identity is maintained. An integrative preference-based model of care has emphasized the theoretical importance of preferences while also identifying the need to understand the mechanisms through which preference-congruent care may affect well-being [6]. This distinction prevents a conceptual model from merely renaming established person-centred principles. A preference has practical significance only when it can be interpreted, communicated, negotiated, and enacted within the conditions in which care occurs.

Direct accounts from nursing-home residents with dementia reinforce the importance of that implementation problem. Residents have described discrepancies between what matters to them and the routines or working conditions that structure their care [7]. Such discrepancies should not be read as evidence that institutional routines are inherently harmful. Predictable routines may support safety, comfort, continuity, and efficient coordination. The relevant question is whether routine remains responsive enough to accommodate what matters to a particular resident when accommodation is clinically and practically possible.

The effectiveness literature also discourages an overly simple equation between person-centred practice and improved outcomes. Systematic review evidence in dementia care indicates that effects vary according to intervention form and measured outcome [8]. Person-centredness is therefore an ethical and relational orientation as well as an empirical intervention category, and those two uses should not be conflated. A resident may experience a practice as respectful or identity-affirming even when the available evidence does not establish measurable improvement in broader clinical outcomes. Conversely, an intervention described as person-centred cannot be assumed to preserve identity merely because it carries that label.

End-of-life nursing further intensifies the relevance of embodied dignity. Ethnographic study of bodily care in nursing homes has shown that waiting, vulnerability, respect, responsiveness, and protection of integrity can affect how dignity is experienced near the end of life [9]. Everyday identity preservation intersects with this evidence because rituals and routines occur within bodily dependency. A preferred morning sequence, grooming practice, way of dressing, or pattern of assistance may express identity, but its meaning depends on how care is delivered and whether the resident experiences the interaction as respectful.

Family involvement adds another layer of complexity. Interpretative synthesis indicates that family participation in nursing-home care depends on trust, relationships with staff, expectations of responsibility, and organizational conditions [10]. Families may carry detailed knowledge of a resident's long-standing practices and may help sustain continuity when communication becomes difficult. They may also hold interpretations that differ from the resident's current wishes. Family involvement is therefore a potentially valuable continuity resource rather than an automatic authorization to define what identity preservation requires.

Cultural and linguistic conditions further complicate recognition. Qualitative synthesis concerning ethnic-minority nursing-home residents has shown that language, culturally meaningful communication, and social conditions influence opportunities to express needs and participate in care [11]. Identity-preserving nursing should consequently avoid converting culture into a fixed catalogue of expected preferences. Cultural knowledge may help staff ask better questions, but it cannot replace attention to the individual person.

Implementation depends equally on nursing conditions. Reviews of nurses' and nurse aides' experiences of person-centred care identify workload, teamwork, relational continuity, communication, and training as important influences on what can be achieved in practice [12]. A conceptual model that ignores such constraints risks turning person-centred care into a moral demand placed exclusively on individual nurses. Institutional feasibility must instead be treated as part of the phenomenon itself: an identity-supportive practice requires a meaningful resident preference and some workable means of incorporating it into care.

Taken together, the evidence indicates that identity-preserving care cannot be inferred from the presence of a personal object, the documentation of a preference, or the declaration of person-centred values. Identity expression, material familiarity, and preference-responsive care intersect through mechanisms that remain relational and context dependent [1, 3, 6]. The same caution applies to dignity, family participation, and cultural responsiveness: each can support continuity, but each is mediated by the conditions in which care takes place [9-11].

The practical implication is a distinction between identity-bearing possibilities and identity-preserving care. A ritual, object, relationship, or preferred schedule becomes identity-relevant only when it has meaning for the resident. It becomes part of identity-preserving care only when staff can recognize that meaning, determine whether and how it remains wanted, and integrate it into care without ignoring clinical or organizational realities. The relationships established in this background are consolidated in **Table 1**.

Table 1. Everyday identity-bearing practices and the institutional conditions that shape their preservation

Identity-bearing practice domain	How identity may be expressed	Nursing recognition required	Institutional condition that may constrain enactment	Negotiable adaptation	Interpretive boundary
Personal rituals	Repetition of personally meaningful acts, sequences, or habits	Determine whether the practice remains meaningful now and what aspect of it matters	Fixed schedules, staffing patterns, symptom-management demands, safety procedures	Preserve the meaningful component while changing timing, duration, assistance, or setting when necessary	Repetition is not inherently identity-preserving; an unwanted ritual should not be maintained simply because it was historically important
Familiar and functional objects	Self-presentation, memory cueing, comfort, activity, practical agency, or connection to previous roles	Establish the person-specific meaning and current usability of the object	Limited space, infection-control requirements, loss risk, accessibility restrictions, cognitive or sensory change	Retain, reposition, simplify access to, substitute, or temporarily withdraw an item according to current circumstances	Objects have no universal therapeutic status; their meaning depends on person, context, and use
Temporal preferences	Preferred times or sequences for waking, washing, eating, resting, socializing, or quiet	Identify which aspects of timing are important and whether the preference remains current	Medication schedules, staffing cycles, shared services, urgent clinical needs	Create bounded flexibility, alternate sequences, or priority periods	Institutional routine is not intrinsically opposed to identity; predictability may itself be valued

Relationship continuity	Familiar staff interactions, family contact, preferred forms of conversation, companionship, or privacy	Clarify who the resident wants involved and in what role	Staff turnover, visiting restrictions, competing family expectations, communication barriers	Protect preferred contact where feasible while renegotiating roles as needs change	Familiarity does not authorize family or staff to override the resident's present wishes
Bodily and self-presentation practices	Preferred grooming, clothing, touch, positioning, assistance, and privacy	Recognize bodily care as relational rather than purely task based	Dependence, time pressure, symptom burden, safety needs	Preserve meaningful choice within clinically necessary care	Identity preservation cannot justify avoidable discomfort, unsafe care, or coercion
Cultural or linguistic practices	Language, food-related practices, forms of address, religious or cultural routines, interpersonal norms	Ask how cultural meaning is expressed for this individual	Limited language support, standardized services, assumptions based on group membership	Use interpreters, family knowledge, adapted routines, or individualized communication when appropriate	Cultural knowledge must inform inquiry rather than predetermine preference

Note: The table represents an analytical synthesis of the selected literature. The categories describe conditions under which everyday practices may become identity-bearing; they are not a standardized assessment scale or validated clinical protocol.

Data sources

This paper uses a deliberately selected conceptual evidence base rather than a systematic review. The purpose of the literature was to test and refine the relationships among everyday preference, material familiarity, nursing routines, family participation, dignity, communication, and institutional feasibility. Sources were therefore selected for their capacity to clarify concepts, expose contradictory or conditional findings, or establish boundaries on what may reasonably be inferred. No claim is made that the corpus represents an exhaustive enumeration of all end-of-life or nursing-home literature.

One evidence stream concerns the elicitation and measurement of everyday preferences. An evidence map of instruments designed to assess older people's preferences identified substantial variation in the domains captured and the settings in which instruments have been used [13]. This variation is important conceptually. What is documented as a preference depends partly on what clinicians and researchers decide to ask. A structured instrument can make preferences visible, but it may underrepresent tacit routines, material attachments, relational expectations, or forms of identity that do not fit predetermined categories.

A second stream concerns communication about end-of-life preferences. Qualitative evaluation of a card-based conversation tool in residential elder care found that structured prompts could help staff approach difficult topics and organize discussion, while use remained dependent on context and individual circumstances [14]. Such findings support the value of intentional elicitation without establishing that a particular tool improves resident outcomes. For the present conceptual analysis, the important point is that recognition is an interactional achievement: preferences become clinically usable when residents, families, and staff have adequate opportunities to express and interpret them.

A third stream concerns the conditions under which such conversations occur. Nursing-home staff have described time, staffing, teamwork, and organizational pressures as influential in the timing and quality of end-of-life communication [15]. Recognition therefore cannot be treated as a purely interpersonal skill. A nurse may understand the importance of discussing preferences yet lack continuity, time, or organizational support to translate that understanding into sustained care. This makes the institutional environment part of the explanatory model rather than external background.

A fourth stream concerns environmental familiarity and flexible models of care. Qualitative work in small-scale dementia care has described responsiveness, familiar surroundings, community connection, and flexible practices as valued characteristics of a more home-like environment [16]. Such evidence is informative but context bound. It does not justify the inference that a small-scale or home-like model is superior in every setting, nor that environmental familiarity alone preserves identity. It does, however, show why spatial and material arrangements belong alongside relational and temporal practices in a theory of everyday identity.

Across these evidence streams, three distinctions guide interpretation. First, resident-reported meaning is given greater conceptual authority than assumptions made solely from institutional convention. Second, family and staff

evidence is treated as relationally valuable but not automatically equivalent to the resident's own preference. Third, evidence supporting the ingredients of identity-responsive care is kept separate from the paper's proposed synthesis linking those ingredients. This distinction is essential because the literature does not directly test the Everyday Identity Preservation Model as an integrated intervention.

The evidence architecture informing that synthesis is shown in **Figure 1**. It visualizes how resident-selected identity cues, environmental familiarity, nursing recognition, relational negotiation, and institutional conditions can interact without treating any single element as sufficient for identity preservation.

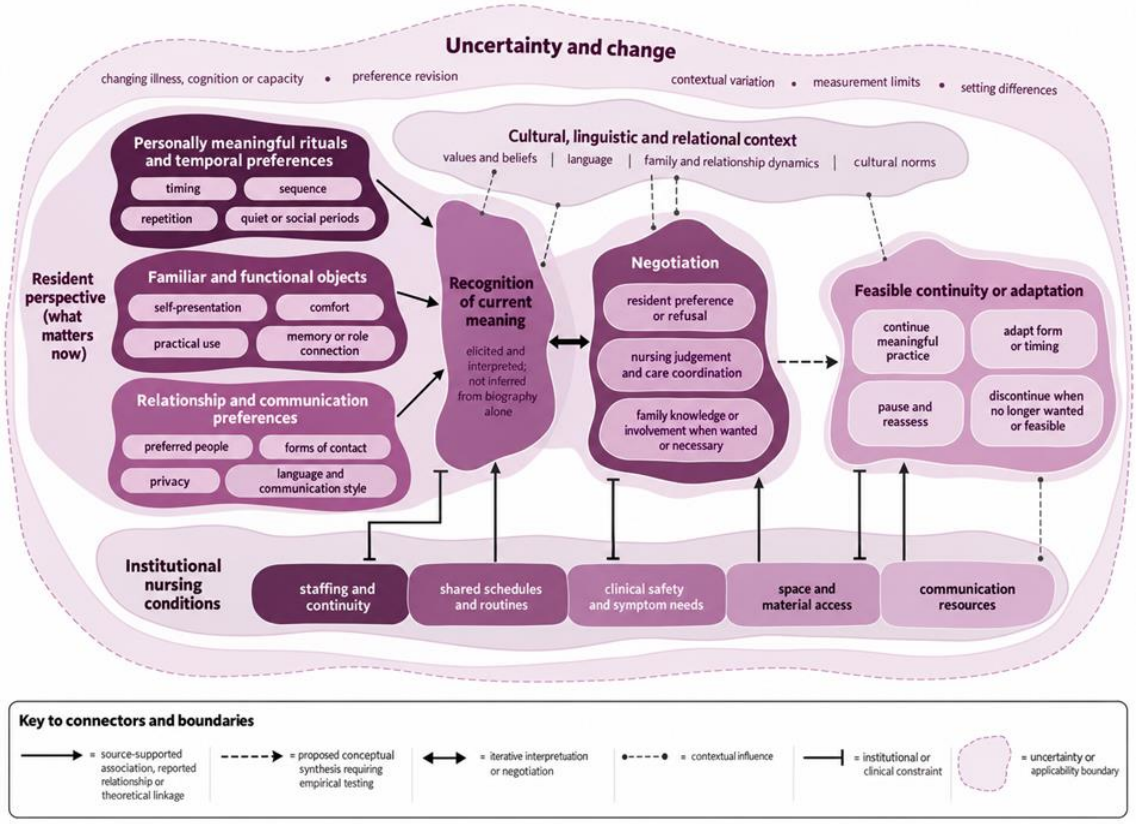


Figure 1. Evidence architecture for everyday identity preservation across personal meaning, environmental familiarity, and institutional nursing practice

Overview of the issues

The evidence reviewed above raises a practical problem that is more complex than whether staff should respect preferences. Institutional end-of-life care involves multiple sources of authority and vulnerability. Residents may have clearly expressed wishes, family members may hold long-standing knowledge, nurses may observe changing clinical needs, and organizations must coordinate care across staff, shifts, spaces, and safety requirements. Everyday identity is therefore preserved, altered, or lost through a series of small negotiations rather than through a single care-plan decision.

A first issue is preference heterogeneity. Survey research among frail nursing-home residents has shown variation in end-of-life preferences and imperfect concordance between residents and family members [17]. The implication is not that families are unreliable, but that resident and family perspectives should not be presumed to coincide. In practice, familiar objects or rituals may be especially vulnerable to proxy assumptions because they appear biographical: a relative may know what a resident always did, yet the resident may no longer want that practice or may want it enacted differently.

A second issue concerns shared decision-making under institutional conditions. Multilevel research in long-term care indicates that shared decision-making is associated with person-centred attitudes, communication, and organizational climate [18]. Such associations do not establish a simple causal sequence, but they reinforce the need to treat negotiation as more than an individual nurse's conversational skill. An institution can formally endorse autonomy while providing little time, continuity, or flexibility for preferences to influence actual routines. That gap is visible in research examining autonomy-supportive care environments. Organizational policies may articulate person-centred values while physical environments, work practices, and collaboration patterns continue to constrain resident autonomy [19]. Everyday identity therefore requires a distinction between formal permission

and practical usability. A resident may theoretically be allowed to choose when to rest or how to personalize a room but still lack the staffing, space, assistance, or continuity required to exercise that choice meaningfully.

A third issue is the temptation to standardize what person-centred routine should look like. National nursing-home data show that residents' daily-care and activity preferences form distinct patterns rather than one uniform profile [20]. These patterns are analytically useful because they demonstrate heterogeneity, yet they should not be converted into resident "types." The relevant unit remains the individual person whose preferences may cross categories and change over time. For one resident, evening solitude may be important; for another, evening contact may sustain continuity. Increasing activity, socialization, environmental stimulation, or family involvement cannot therefore function as universal identity-preserving strategies.

A fourth issue is refusal. Ethnographic analysis of nursing-home residents' refusals illustrates how saying "no" can expose the politics of institutional care and the limits of assumptions about responsibility and compliance [21]. Refusal should not automatically be celebrated as autonomous identity expression, because it can also arise from pain, fear, confusion, communication difficulty, or unmet clinical need. Yet neither should refusal be treated merely as an obstacle to completing routine care. Within an identity-preservation perspective, refusal is information requiring interpretation. A previously valued ritual that is declined today may signal a temporary problem, a changed preference, or a broader shift in how the resident wants to live.

Family involvement creates a fifth issue because continuity and authority may pull in different directions. Repeated interviews with families of residents in dementia special-care units demonstrate how involvement is shaped by relationships, responsibility, trust, communication, and staff shortages [22]. Families may help staff understand subtle preferences, maintain familiar practices, or supply objects that carry personal meaning. At the same time, family involvement can become ethically difficult when the resident's present expression differs from the family's account of who the person "really is." Identity preservation cannot legitimately become restoration of a former self against the current person's wishes.

These issues converge around negotiated routines. A negotiated routine is not simply a compromise between resident desire and institutional convenience. It is a care arrangement in which staff identify what aspect of a practice carries meaning, determine whether the person currently wants it, consider whether clinical or organizational conditions constrain it, and then preserve or adapt the meaningful component where possible. Negotiation may produce continuity, modification, temporary suspension, or discontinuation. Each can be person-centred if it reflects the resident's current circumstances rather than an institutional preference for sameness.

Negotiation also has a temporal dimension. End-of-life care can involve rapidly changing fatigue, cognition, symptom burden, ability to communicate, tolerance of stimulation, and family presence. A rigid commitment to a previously documented routine can become as insensitive as ignoring the preference altogether. Continuity therefore needs to be interpreted as continuity of personally meaningful agency and recognition, not necessarily continuity of identical behaviour.

The strongest reason for this caution is that resident preferences, population-level preference patterns, and family involvement all demonstrate meaningful variation [17, 20, 22]. A model of everyday identity preservation must therefore resist the idea that institutions can create a standard inventory of identity-preserving actions. What can be standardized is the obligation to inquire, interpret, negotiate, reassess, and document the reasoning behind adaptations.

Table 2 differentiates the components of negotiated person-centred routines without converting them into a fixed clinical algorithm.

Table 2. Components of negotiated person-centered routines in institutional end-of-life care

Negotiation component	Primary question	Resident contribution	Nursing contribution	Family contribution where appropriate	Institutional feasibility consideration	Acceptable forms of continuity
Current meaning	What does this practice, object, timing preference, or relationship mean to the resident now?	Expression, assent, refusal, behaviour, preference, or previously communicated values interpreted cautiously	Elicit meaning, observe response, avoid automatic assumptions	Offer contextual knowledge without displacing current resident expression	Provide time and communication support sufficient for interpretation	Continue only elements that retain present meaning

Preferred form	Which part of the practice matters most?	Identify or demonstrate important elements where possible	Distinguish essential meaning from incidental details	Clarify long-standing forms when useful	Determine what can be accommodated within available space, staffing, equipment, and schedule	Preserve core meaning while modifying nonessential form
Timing and repetition	When and how often is the practice wanted?	Indicate preferred timing, tolerance, or changing interest	Reassess with changes in fatigue, symptoms, cognition, or care needs	Help interpret established rhythms when resident communication is limited	Coordinate with medication, meals, staffing, rest, and shared services	Maintain preferred timing, create bounded flexibility, or reschedule
Relational involvement	Who should participate, assist, observe, or remain absent?	Define desired contact and privacy to the extent possible	Protect consent, privacy, and manageable interaction	Participate according to resident preference, role, and clinical circumstances	Account for staff continuity, visiting conditions, language support, and space	Sustain valued relationships without making involvement compulsory
Clinical compatibility	Can the practice coexist safely with current care needs?	Communicate comfort, distress, acceptance, or refusal	Evaluate symptom burden, safety, treatment demands, and proportionality	Contribute information but not independently determine clinical appropriateness	Provide alternatives where routine restrictions are necessary	Adapt sequence, assistance, duration, location, or object access
Reassessment	Does the arrangement still fit the resident?	Express change, uncertainty, or refusal	Revisit meaning after clinical or behavioural change	Update contextual information while respecting current wishes	Ensure care plans can be revised rather than merely copied forward	Continue, modify, pause, substitute, or discontinue
Disagreement	What happens when resident, family, staff, or organizational priorities diverge?	Resident preference and current expression remain central within applicable capacity and safety limits	Clarify reasons, seek workable alternatives, document unresolved tension	Explain concerns and participate in dialogue without presumed authority	Escalate appropriately when safety, resources, policy, or ethical conflict requires review	Preserve as much personally meaningful continuity as circumstances permit

Note: The table presents a conceptual organization of negotiation. It is not a validated decision tool, scoring system, or mandatory sequence. Individual components may occur repeatedly or simultaneously, and some may be unnecessary in straightforward situations.

Conceptual findings

The evidence supports an understanding of everyday identity as something enacted through ordinary choices, relationships, objects, bodily practices, and temporal patterns rather than preserved solely through knowledge of biography. The Everyday Identity Preservation Model therefore organizes institutional end-of-life nursing around three interdependent functions: recognition, negotiation, and continuity. These functions describe a proposed conceptual relationship rather than an empirically validated clinical pathway.

Recognition concerns identifying what currently carries personal meaning for the resident. Nursing accounts of person-centred care emphasize communication, participation, partnership, and self-determination as important elements of responsive practice [23]. Within the present model, recognition extends this principle to the seemingly ordinary practices through which a person remains recognizable to themselves and others. A particular sequence before sleep, a preferred form of grooming, a familiar object, a quiet period after meals, a customary form of address, or contact with a particular person may therefore warrant attention when it remains meaningful to the resident.

Recognition is deliberately distinguished from biographical reconstruction. Knowledge of a person's past can guide inquiry, especially when communication becomes difficult, but past identity cannot automatically determine present preference. What a person valued previously may remain important, become less important, or acquire a

different form as illness progresses. Recognition consequently requires sensitivity to present verbal communication, behaviour, assent, refusal, comfort, distress, and relational context.

Negotiation begins when an identity-bearing preference encounters other legitimate considerations. These may include symptom burden, treatment requirements, staffing, environmental restrictions, other residents' needs, family expectations, infection prevention, safety, or changing capacity. Negotiation does not mean that every preference must be compromised. Some can be accommodated directly. Others require adaptation, and some cannot reasonably be enacted under current conditions. The conceptual requirement is that the reason for alteration should arise from an identifiable clinical, relational, or organizational constraint rather than from unexamined institutional habit.

Resident refusal is particularly important within this function. A refusal may indicate that a formerly meaningful practice is no longer wanted, that its timing is wrong, or that discomfort or communication difficulty has altered the situation. The model therefore treats refusal as information to be interpreted before continuity is pursued. Preserving identity cannot legitimately require preserving a practice against the current person's resistance.

Continuity describes the feasible maintenance of personally meaningful patterns over time, but it does not mean behavioural sameness. Research on social participation in nursing homes demonstrates that residents differ substantially in what kinds of participation they value and that individual or quieter forms of activity may be as meaningful as collective engagement [24]. Continuity must therefore be indexed to the resident's own experience. For one person it may mean preserving a familiar evening routine. For another it may mean retaining control over clothing, maintaining contact with a particular relative, listening to familiar music, or being left undisturbed at a valued time.

This interpretation allows continuity to include adaptation. A ritual may be shortened because of fatigue, an object repositioned because mobility has changed, family participation reduced because the resident wants greater privacy, or a preferred schedule modified around symptom control. The preservation target is the meaningful function of the practice where possible, not exact replication of its previous form.

The model also requires an explicit evidence boundary. Systematic review evidence of person-centred dementia care shows heterogeneous implementation and mixed effects across measured outcomes [25]. The proposed relationships among recognition, negotiation, and continuity therefore should not be interpreted as proof that identity-preserving practices improve quality of life, agitation, survival, symptom control, or other clinical outcomes. The model instead identifies a conceptual nursing responsibility and a set of relationships that require empirical testing.

Figure 1 captures this distinction by separating source-supported observations from the proposed links that integrate them. Personal rituals, objects, relationships, and temporal preferences become relevant only when they are meaningful to the resident; nursing recognition alone is insufficient unless institutional conditions permit meaningful enactment; and continuity remains conditional on reassessment. The model's distinctive contribution is consequently not a new catalogue of person-centred activities. It is the proposition that institutional end-of-life care should preserve opportunities for a person to remain recognizably themselves through current meaning, negotiated feasibility, and revisable continuity.

Results and Discussion

The Everyday Identity Preservation Model reframes a familiar problem in institutional care. Person-centred nursing commonly endorses individualized preferences, dignity, shared decision-making, and family involvement. The present analysis argues that these elements become especially consequential when they determine whether ordinary identity-bearing practices remain possible near the end of life. Nursing work is therefore implicated not only in major treatment decisions but also in the organization of everyday time, material surroundings, bodily care, communication, relationships, and opportunities for refusal.

This argument should not be converted into an additional checklist imposed on already complex end-of-life care. Palliative needs in nursing homes span multiple clinical and psychosocial domains, and decisions about specialist involvement remain context-sensitive [26]. When severe symptoms, urgent treatment needs, or safety concerns conflict with a preferred routine, clinical care may appropriately take priority. The identity-preserving question then becomes whether the meaningful component can be retained or restored in another form, rather than whether routine continuity must prevail over clinical judgement.

The model also distinguishes recognizing a preference from enacting it. This separation is important because documentation can improve without ensuring that a resident experiences care as congruent with what matters to them. Evidence from nursing-home advance care planning shows that structured interventions can increase documentation while not consistently improving all experiential outcomes [27]. A recorded preference is therefore a resource for care, not evidence that meaningful continuity has occurred.

For nursing practice, this distinction shifts attention from the completeness of preference records toward what happens after preferences become known. Care planning should remain capable of recording why a practice matters, which part of it is essential, what adaptations are acceptable, and when reassessment is needed. Such

documentation would be more consistent with the model than merely recording that a resident "likes" or "does not like" a particular activity. The proposal remains conceptual, however, and should not be treated as a validated documentation standard.

Family participation requires similar restraint. Systematic qualitative evidence indicates that families associate good nursing-home end-of-life care with attention to residents' wishes, continuity, communication, support, and partnership [28]. Families may therefore be indispensable sources of relational and biographical knowledge, particularly when residents have difficulty communicating. Their knowledge nevertheless remains interpretive. When a resident's current expressions conflict with family expectations, preservation of identity should not automatically mean preservation of the identity preferred by relatives.

Institutional feasibility is another central limitation. Flexible scheduling and individualized routines require staff time, continuity, communication, and managerial permission. Some adaptations may be achieved through small changes, whereas others depend on resources unavailable in a particular institution. The model does not resolve structural understaffing by assigning nurses a stronger moral obligation. Its organizational implication is instead that facilities claiming to provide person-centred end-of-life care should examine whether their routines allow clinically reasonable preferences to influence everyday practice.

Evaluation also requires caution about outcome selection. Longitudinal evidence based on family perspectives has shown that improvements in perceived quality of care do not necessarily produce parallel improvements in perceived quality of dying [29]. Organizational indicators, completion of care plans, or family satisfaction therefore cannot be assumed to capture preservation of everyday identity. Future studies would need measures capable of distinguishing whether preferences were identified, whether meaningful practices were actually enacted, whether adaptations remained acceptable to residents, and whether experience changed over the trajectory of dying.

Empirical validation of the model should begin with construct development rather than premature effectiveness testing. Research is needed to examine whether recognition, negotiation, and continuity can be distinguished reliably in practice and whether residents, families, and nurses understand these concepts similarly. Longitudinal qualitative work could clarify how identity-bearing practices change as illness advances. Observational research could examine how staffing continuity, unit routines, material environments, and family presence influence enactment. Where residents can report their own experience, direct resident evidence should remain central rather than relying exclusively on proxy judgements.

Cultural validation is equally necessary. Identity-bearing routines cannot be assumed to have equivalent meanings across settings, cultural groups, or health systems. Cultural and religious practices may be important sources of continuity, but standardized assumptions about them risk reproducing the same institutional simplification that the model is intended to challenge. Cross-cultural research should therefore test the process of individualized recognition rather than compare residents according to presumed cultural preference profiles.

The model has several conceptual limitations. Much of the supporting literature comes from nursing homes, residential aged care, and dementia care rather than exclusively from residents formally identified as being in the final days or weeks of life. Evidence concerning everyday preference and material familiarity is therefore used to inform an end-of-life conceptual argument, not to demonstrate a terminal-phase intervention effect. The evidence base also includes substantial qualitative and observational research, which is appropriate for questions of meaning and experience but cannot establish the causal effectiveness of the proposed model.

A further limitation is that continuity itself can become ethically problematic. Identity changes throughout life, and serious illness may alter relationships, preferences, tolerances, and priorities. Nursing care should not turn past biography into an obligation to remain the same person in the same way. The resident's present expression must retain interpretive priority wherever it can be meaningfully obtained. Preserving everyday identity is consequently best understood as protecting opportunities for personally meaningful continuity while permitting change.

These boundaries clarify the contribution of the model. It does not claim that rituals or familiar objects are treatments, that institutional routines are intrinsically harmful, that families reliably represent resident wishes, or that preference fulfilment guarantees better clinical outcomes. It proposes that everyday identity becomes clinically relevant when personally meaningful practices encounter institutional care, and that nursing can respond through a disciplined sequence of recognition, negotiation, reassessment, and feasible continuity. Whether this approach improves resident experience or other outcomes remains an empirical question.

Conclusion

Institutional end-of-life care does not suspend the significance of ordinary life. Personal rituals, familiar and functional objects, preferred rhythms, relationships, bodily practices, and opportunities for refusal can remain ways through which a resident expresses who they are. Their importance, however, cannot be presumed from biography, diagnosis, culture, or family expectation.

The Everyday Identity Preservation Model conceptualizes person-centred nursing as the recognition of current meaning, negotiation of feasible care, and preservation or adaptation of continuity over time. It deliberately allows practices to change, pause, or end when resident preference or clinical circumstances change.

Preserving everyday identity should therefore be understood as an explicit but conditional nursing responsibility: to keep personally meaningful ways of living visible within institutional care while respecting present wishes, clinical needs, relational complexity, and organizational realities.

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