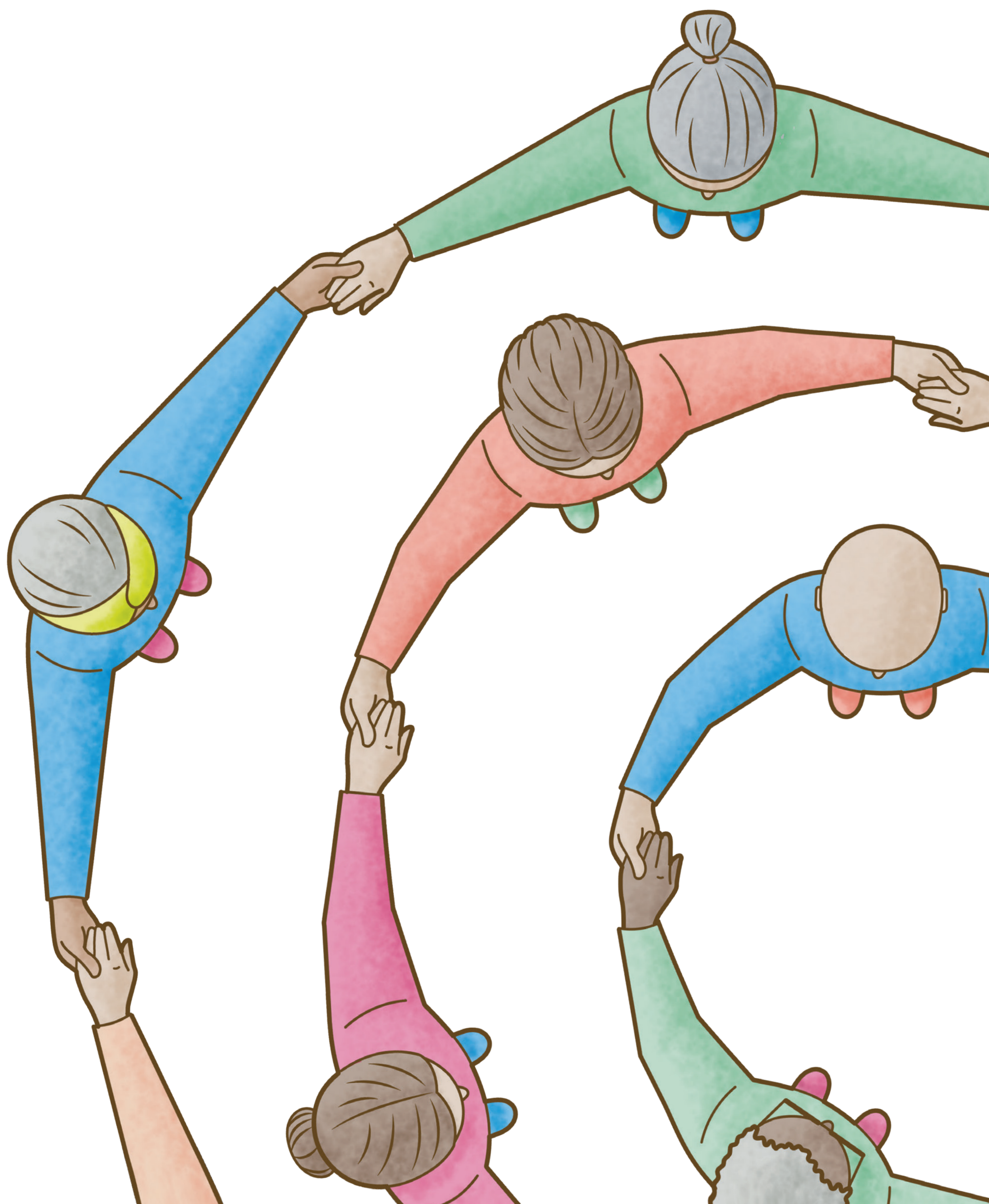
ARE WE WALKING OR JUST TALKING?

Enhancing relationship-centered care in nursing homes

Johanna Rutten



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Johanna Elisabeth Regina Rutten

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Johanna Elisabeth Regina Rutten

Promotor
Prof. dr. H Verbeek

Copromotoren
Dr. R Backhaus
Dr. KYJ Sion

Beoordelingscommissie
Prof. dr. DJA Janssen (Maastricht University) (voorzitter)
Prof. dr. S Brand-Gruwel (Maastricht University)
Prof. dr. E Finnema (University of Groningen)
Prof. dr. RJJ Gobbens (University of Tilburg)
Prof. dr. T Huijts (Maastricht University)

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CHAPTER 1

General Introduction

It's lunchtime at the nursing home, the Sunflower. Seven residents sit together at the table and eat together with the care staff. "Home is where the heart is" is written in colorful letters on the wall behind the dining table. Mrs. Janssen moved in 6 months ago. For lunch she is sitting at a table with the other residents. She grew up in a large family and enjoys having other people around her. Therefore, she appreciates knowing the other 6 residents and seeing them every day. After a bumpy start and getting used to the new environment, she now feels comfortable at the Sunflower.
To her left is her daughter, Anna. Anna and her mother did not always see eye to eye in the past, so there were often arguments. In recent years, however, Anna has cared for her mother at home. During this time, their relationship has become very close. Mrs. Janssen really enjoys her daughter's visits. During lunch Anna always helps her mother with the meal. "At least there's something I can still do for my mother", she thinks. Since her mother moved to the nursing home, Anna is struggling with her role as family caregiver. She is not sure what she is allowed or expected to do and when she gets "in the way".

For Lisa, Mrs. Janssen's favorite nurse assistant, it is another busy day, and everyone seems to want something from her. She feels like she cannot live up to everyone's expectations. Secretly, she is glad that Anna is there to help her mother during lunch because Lisa does not have much time today. She regrets this because Mrs. Janssen is actually one of her favorite residents.

This example illustrates an everyday situation in a nursing home. Residents, their family members, and nursing home staff are three different groups of actors with their own individual needs, perspectives, and perceptions about the same situation. The relationship between the resident, their family members, and the nursing home staff forms the basis for good care and well-being for the resident. Centering the care around the resident and considering their relationships is what defines the concept of person- and relationship-centered care. In recent years, this concept has become the guiding principle within nursing home care. This dissertation focused on discovering how relationship-centered care in nursing home settings can be enhanced. In the first chapter, the general concepts of the nursing home setting and relationship-centered care are introduced.

Nursing homes

A nursing home has been defined as "*a facility with a domestic-styled environment that provides 24-hour functional support and care for persons who require assistance with ADLs and who often have complex health needs and increased vulnerability. Residency within a nursing home may be relatively brief for respite purposes, short term (rehabilitative), or long term, and may also provide palliative/hospice and end-of-life care*".[1] Dutch nursing homes consist of 3 main kinds of wards: psychogeriatric wards designed for residents with cognitive impairments, somatic wards for residents with physical disabilities, and rehabilitation wards dedicated to residents requiring short-term care.[2]
In the Netherlands, most nursing home residents are 85 years of age or older, with women comprising 73% of the residents.[3] In 2019, 115000 people were living in a nursing home in the Netherlands. Due to the ageing population, the number of people living in or waiting to move to a nursing home is increasing every year.[4]
After an older person moved into a nursing home, their family or close friends are often still involved in various ways. Family caregivers in the Netherlands may execute different tasks in the nursing home such as helping with daily tasks (e.g., eating) or taking a walk with the residents.[5]
Nursing home staff generally receive specialized training to care for the residents. In the Netherlands, nursing home staff mainly consist of certified nurse assistants ("verzorgenden") and nurse assistants ("helpenden"). Nursing home residents receive medical care from nursing home medical specialists, a unique service in the Netherlands.[6] The nursing home employs these medical specialists as well as any related health professionals (e.g., physiotherapists, psychologists, occupational therapists).[7] A recent

trend in Dutch nursing homes has been to hire staff other than those responsible for direct care. Examples of this are staff responsible for activities or the social well-being of the residents, without a background in healthcare.

Relationship-centered care

Caring for the residents and assistance with everyday life are the most crucial aspects of nursing home care. Nursing home residents are individuals with their own histories, personalities, (family) relationships, and their own wishes and preferences.[3]
In the past, nursing care was mostly task-centered, emphasizing the allocation of work according to the completion of tasks and procedures.[8] In this context, little attention was given to the individual wishes and preferences of residents, with a greater emphasis placed on physical care. Currently, nursing homes are experiencing a culture shift from focusing solely on tasks to prioritizing individuality in the provision of care.[9]
As a result of recent developments, these wishes and preferences have become increasingly important not only for the daily care of residents, but also in quality management. How residents experience the delivered care has become an important quality indicator. Therefore, it is increasingly important to identify and measure how the quality of care is experienced. Research has shown that the perception of the quality of care is a process consisting of expectations, interactions, and relationships that occur during the caring process.[10] Furthermore, everyone involved in the care process – residents, family members, and nursing home staff – has different needs and perspectives on the quality of care.[11] To obtain a comprehensive understanding, all perspectives should be accounted for.

The concept of person- centered care puts the person in the center of the care process while considering their context, personal history, family dynamics, as well as their unique strengths and vulnerabilities.[12]
The concept of relationship-centered care acknowledges the individual as a stakeholder in their interactions and considers relationships, different needs, wishes, and perspectives that arise during the care process. [13,14] Relationship-centered care is based on four principles: first, that personhood matters; second, that affect and emotion are important; third, that relationships do not occur in isolation; and fourth, that maintaining genuine relationships is necessary for health and recovery, and is morally valuable.[14]

Relationship-centered care in practice

Although the concept of relationship-centered care has been well studied and described in the literature, providing it on a daily basis in nursing homes is challenging.[15-17] An equal partnership between residents, their family members, and nursing home staff is difficult to achieve.[18] While relationship-centered care emphasizes prioritizing residents' needs, wishes, and relationships, the reality often entails residents having to adapt to the routines and schedules of the nursing home rather than maintaining their own daily routines.[19] This adaptation not only has an impact on the daily lives of the residents, but also on how they continue their relationships with their families after they have moved into the nursing home. Earlier studies indicate that despite their good intentions, nursing home staff may inadvertently overlook residents' daily needs and wishes by excessively relying on preferences outlined in care plans or past encounters.[20] This is particularly problematic for residents with dementia. They become highly dependent on nursing home staff and frequently struggle to express their needs and desires. Thus, they often require support in their interpersonal relationships for them to express their wishes and preferences.[21]
Also, maintaining a meaningful relationship between residents and family members is a crucial aspect of providing care in a relationship-centered way. When entering a nursing home, new residents get disconnected from aspects of their former lives, including family routines, meaningful belongings, and social networks and relationships.[22] Relationships in general can be a source of satisfaction and happiness, and a lack of them can cause loneliness and isolation.[23] The relationships with their remaining family members and friends provide a connection for the residents to their former lives and the world

outside the nursing home.[22] Maintaining a reciprocal relationship with family members has been recognized to benefit residents', and also family members' well-being.[13,22,24] Furthermore, research has indicated that family members can play a crucial role in offering emotional support, lowering stress levels, and assisting with answering questions.[25-29] From the perspective of the resident, this relationship has been described in terms of "help provision", giving love and joy and providing meaning in old age.[13] Many family members appreciate staying involved in the care process of their loved ones.[30,31] Consequently, the relationships between family and staff are important. Effective relationships between staff and family have been linked to the experience of a better quality of care.[24,32] Nonetheless, family members often experience difficulties in forming reciprocal relationships with staff.[21,33] Prior studies have indicated that although family engagement is regarded as a crucial aspect of everyday life in nursing homes, there are still difficulties in collaborations between family members and staff.[34] Dutch family members involved in resident caregiving have stated they have limited involvement in the decision-making process regarding the care of their loved ones.[35] While nursing home staff acknowledge the value of family and volunteers, they tend to lean towards performing tasks on their own. Family members are often perceived as "visitors" in their working area.[34] Additionally, nursing home staff find collaboration and communication with family members challenging and often attempt to avoid interactions, possibly due to a lack of knowledge on effective communication techniques.[36]

The role of nursing home staff in providing relationship-centered care

As nursing home staff spend most of their time with the residents, they play a major role in the enhancing relationship-centered care in practice.[37] According to previous research, providing relationship-centered care not only has positive effects for residents, but also for the staff. The chance to practice relationship-centered approaches within nursing homes has, for instance, been positively associated with higher levels of job satisfaction.[38,39] Additionally, working in a relationship-centered way can allow nursing home staff to merge aspects of their personality with their role as a healthcare professional.[40]

Previous research that explored the implementation of RCC in practice identified various facilitating conditions in different healthcare settings.[41-43] These studies indicate that different characteristics of the work environment – the context in which the care is delivered – seem to play an important role in successful implementation. Supportive organizational systems have been referred to as prerequisite for relationship-centered care, as they facilitate shared-decision making and provide an appropriate skills-mix within teams. Additionally, the sharing of power and the potential for innovation should be considered.[43] Furthermore, the importance of the quality of nursing leadership was emphasized in earlier studies.[40,44,45] The behavior of nursing leaders has been associated with relationship-centered care and contributes to the psychosocial environment for both staff and residents in nursing homes.[44,46]

In addition to the work environment, various staff characteristics that promote relationship-centered care have been identified in the literature. Compassion, acceptance, and persistence in applying relationship-centered care principles have been reported as crucial for enhancing relationship-centered care.[47,48] Furthermore, communication styles, acknowledging each resident as an individual, and building strong relationships have been associated with relationship-centered care.[37] Preferably, nursing home staff acquire these skills during their professional training and develop them further in the course of their careers.[49] A recent study indicated that nursing home staff who participate in continuous professional development are inclined to deliver relationship-centered care more consistently.[50] Hence, it appears crucial that the training of nurses be adapted in such a way that they learn from the outset to engage in continuous professional development.

Considering the challenges still present in practice, collaborating effectively together with family and residents and building reciprocal relationships require support from the work environment and skills from nursing home staff. Nursing staff must assume new roles and create connections between the different stakeholders. In addition, they have to deal with all the other challenges that the long-term care sector is confronted with, such as staff shortages and increasingly complex health conditions of the residents. However, to overcome the challenges of enhancing relationship-centered care in nursing

home environments, further research is needed to investigate environmental factors. In addition, further research is needed into what skills nursing home staff need to have to facilitate collaboration between family members and residents. Also, it is important to investigate the optimal methods for acquiring these skills to enhance relationship-centered care.

Aim and outline

The aim of this dissertation was to investigate how relationship-centered care in nursing home settings can be enhanced. Therefore, various aspects of the work environment, data usability, and educational experiences of nursing home staff were investigated. The research questions were:

1. Which work environment factors contribute to relationship-centered working? (chapters 2 and 3)
2. How can nursing home staff be facilitated to improve relationship-centered care? (chapters 4, 5, and 6)

In detail, **Chapter 2** presents the results of a cross-sectional study on the relationships between work environment, job characteristics, and person-centered care for people with dementia in nursing homes. **Chapter 3** presents insights into how staff members experienced their work and work environment during the COVID-19 pandemic. **Chapter 4** describes a stepwise approach to use narrative data within resident-family-nursing staff triads in nursing homes for quality improvements. **Chapter 5** reports the results of a qualitative study that aimed to provide insights into improving relationship-centered care during evaluation meetings within the resident-family-caregiver triad in nursing homes. **Chapter 6** identifies how some students experienced learning in a hybrid learning environment and their perceptions on relationship-centered care. Finally, **Chapter 7** summarizes the main findings of these studies, theoretical and methodological considerations are outlined, and recommendations for future research and practice are made.

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CHAPTER 2

Work environment and person-centered dementia care in nursing homes—A cross-sectional study

This chapter has been published as:
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ABSTRACT

Aim: This study aims to explore the relationship between work environment, job characteristics and person-centered care for people with dementia in nursing homes.

Background: Person-centered care approaches have become a dominant indicator for good quality of care in nursing homes. Little is known about the relationship between work environment, job characteristics and person-centered care in nursing homes.

Method(s): Cross-sectional data from the LAD study were used. Direct care staff (*n* = 552) of nursing homes (*n* = 49) filled an online questionnaire about work environment characteristics and person-centered care. To examine relationships, multilevel linear regression analyses were conducted.

Results: Associations were found between a higher transformational leadership style, less social support from a leader, a higher unity in philosophy of care, higher levels of work satisfaction, more development opportunities, better experienced teamwork and staff-reported person-centered care.

Conclusion(s): In a complex nursing home environment, person-centered care is influenced by organizational and work characteristics, shared values and interpersonal relationships.

Implications for Nursing: Leaders may consider facilitating collaboration and creating unity between care staff, clients and family members in order to provide person- centered care. Therefore, a transformational leadership style, educational programs and coaching for leaders are recommended.

INTRODUCTION

Continuously improving quality of care for nursing home residents is challenging for health care organisations. Therefore, improving and measuring the quality of care in nursing homes have been the focus of numerous studies in the past years[1-3]. One factor influencing the quality of care in the nursing home setting is the direct care staff.

The relationship between direct care staffing and quality of care has been investigated in several studies[4,5]. For care staff, characteristics of their work environment and their work processes, such as good communication and coordination, are associated with the quality of care in nursing homes[6-8]. The model of Backhaus et al.[9] suggests that work environment characteristics might mediate the relationship between staffing levels and quality of care. In this context, quality of care is mostly linked to clinical outcomes. Nevertheless, quality of care has been defined by more than clinical outcomes in the past years[3,10].

In dementia care, which represents a large part of all nursing home care, a person-centered approach has become a dominant indicator for high quality of care in the past years[11-13]. In 1997, Tom Kitwood introduced the concept of person-centered care, which means care is not organised around the disease but rather around the person. By putting the person at the centre of care, positive effects on well-being and reduced health issues are expected [11,12,14,15]. The increasing importance of person-centered care as a quality indicator for dementia care requests the investigation of factors influencing person-centered care in nursing homes. Earlier studies have identified several work environment characteristics, such as leadership, as determinants for person-centered care[16-18]. Recently, transformational leadership has become the desired leadership style in nursing[19,20]. The Box 1 provides more insight into transformational leadership.

Moreover, other work environment factors seem to play a crucial role in facilitating person-centered care in nursing homes. Environmental factors, such as positive team climate and work culture, have been associated with better quality of care[7,9]. A cross-sectional study by Van Beek and Gerritsen[21] found that work environment factors are vital to provide individualized quality of care. Therefore, factors such as teamwork might also be associated with person-centered care. An earlier study demonstrated that effective teamwork results in more time to offer residents individualized care[22]. Based on this evidence, the work environment seems to play a crucial role for the delivery of person-centered care.

Comprehensive theoretical models integrating work environment characteristics and their relationship with person-centered care are scarce. Since person-centered care became an important indicator for quality of care, it seems evident to investigate the relationship between work environment factors and person-centered care in nursing homes. In this study, the relationship between work environment characteristics (i.e. transformational leadership, teamwork, unity in philosophy of care), job characteristics (i.e. work conditions, satisfaction, social sup- port, task variation and opportunities, autonomy and organizational commitment) and staff-reported level of person-centered care for people with dementia in nursing homes will be assessed.

BOX 1. Characteristics of transformational leadership

Transformational leadership:

- Can be described as a type of relational leadership in which staff is motivated to achieve organisational goals and has trust and respect for the leader[23];

Transformational leaders:

- Are described as warm and charismatic, with a personal authority that can create change through non-hierarchical teamwork[24];
- In contrast to hierarchical leaders, are more likely to recognize individual care staff preferences;
- Seem to have a positive effect on the well-being of clients[25,26] and improve client outcomes in nursing homes[27];
- Play an important role in promoting a clear philosophy of care to obtain professional development for direct care staff and person-centered dementia care[28];

METHOD

In this study, data from 'Living Arrangements for people with Dementia (LAD)'-study database. The LAD study is a cross-sectional study into quality in a broad scope of dementia care environments in the Netherlands[29]. Every two to three years this study is conducted, using questions related to different topics. We used data from 2016 to 2017 as these were the newest data, providing specific information on the topic of leadership and person-centered care.

Sample

In October 2015, the Trimbos Institute invited 1,728 nursing homes from 363 different health care organisations, listed by the Dutch Ministry of Health, Welfare and Sport, by mail to participate in the monitoring[29]. In this study, data of a subsample were used, consisting of direct care staff (e.g. registered nurses, [certified] nurse assistants) working on a unit for people with dementia. Care staff in training were excluded[29].

Data collection

All data were extracted from the LAD-study database. Participants received an informational letter with login information for the online questionnaire[29]. Care staff working at wards for people with dementia were asked to complete an online questionnaire. To assess the relationship, data on work characteristics, level of transformational leadership, level of teamwork, unity in philosophy of care and level of person-centered care were extracted from the database. Table 1 presents the used variables and the measurement instruments. The level of person-centered care is based on how staff members perceive the care to be person-centered.

Data analysis

Data analyses were performed with SPSS for Windows (version 24). First, sample characteristics, such as distribution and missing data, were explored. In order to prevent bias, 37 respondents who did not fill in most of the questions in the questionnaire were excluded from the original sample (n = 589). The remaining missing data (n = 68) in the new sample were imputed using multiple imputation techniques. To examine the relationship between work environment characteristics, such as transformational leadership, level of teamwork, job characteristics (independent variables) and staff-reported level of person-centered care (dependent variable), multilevel linear regression analyses (random intercept) were conducted, in which staff (level 1) was nested in nursing homes (level 2). We conducted a fully adjusted analysis in which we controlled for background characteristics (i.e. age of staff and role) and applied a significance level of 0.05. As most respondents were female (96%), we did not include the gender of staff as a covariate.
Intraclass correlation coefficients (ICCs) were calculated to test the correlation between staff members working in the same nursing home. With a value of 0.7, the ICC is considered to be moderate[37]. The variance inflation factors (VIFs) were calculated for all independent variables to test for multicollinearity. All values for the calculated VIFs were below 5, which indicates that no multicollinearity problem existed[38]. A moderator analysis was conducted to test for the moderating effect of transformational leadership.

Ethical considerations

All data were extracted from an existing database. The Medical Ethics Committee of the University Medical Center of Utrecht confirmed that the LAD study does not come under the scope of Medical Research Involving Human Subjects Act (reference number WAG/om/13/055932)[29].

Table 1. Study variables and their measurement

	Variable	Measurement
Demographic variables	Age Gender Function	Age in years Male/female Clustered in 3 categories according to educational level and function (Registered Nurse, Certified Nurse assistant, Nurse assistant)
Work environment	Social support from colleagues Social support from leader Autonomy Work conditions Work Satisfaction Task variations & opportunities Organizational commitment	Dutch version of The Leiden Quality of Work Questionnaire (LQWQ))[30] 4-point Likert-scale (1: totally disagree to 4: totally agree); 30 items
	Transformational leadership	Global Transformational Leadership Scale (GTL)[31]; 5-point Likert scale (1: rarely or none of the time to 5: (almost) all of the time); 7 items
	Teamwork	11 statements have been developed by researchers of the Trimbos-institute based on theory about teamwork from Vroemen[32]. The statements contain topics as: open communication, mutual respect, flexible adjustment and showing initiative. 4-point Likert-scale (1: totally disagree to 4: totally agree);
	Unity in philosophy of care	Questionnaire developed based on previous findings of the LAD-study [34]. Statements contain subjects linked to philosophy of care such as challenging behavior, responding to the individual needs of the client and communication with the family carers [35]; 5-point Likert scale (1 :none of the time to 5: all of the time) 7 items
Staff reported person-centered care	Person- centered care	Dutch version of the Person-Centered Care Questionnaire (PCC)[36]; 5 point scale (1: never to 5:always); 34 items

RESULTS

Descriptive statistics

A total of 49 nursing homes from 13 different elderly care organizations participated in the fourth measurement round of the LAD study. These are 3% of the invited nursing homes and 4% of the invited elderly care organizations. In total, 552 staff members from the 49 nursing homes (on average 11 per nursing home, ranging from 2 to 28 per nursing home) completed the online questionnaire, a 36% response rate. Of the 552 respondents, 67% were certified nurse assistants, 22% were nurse assistants, and 10% were registered nurses. Sample characteristics are described in Table 2. Results of the descriptive statistics are reported in Table 3.

Table. 2 Characteristics of the sample (n=552)

Characteristics of participants	
Age (years) *m*(±SD)	44.7 (±12.4)
Gender *n* (%)	
Male	22 (4%)
Female	530 (96%)
Function *n* (%)	
Registered nurse	55 (10%)
Certified nurse assistant	371 (67%)
Nurse assistant	126 (22%)

Table 3. Characteristics of study variables

	m(±SD)	Score range (minimum and maximum)	n
Work conditions †	2.6 (± 0.5)	1.2-4.0	552
Autonomy †	2.9 (± 0.4)	1.3-4.0	552
Social support leader †	3.0 (± 0.6)	1.0-4.0	552
Social support colleagues †	3.2 (± 0.5)	1.3-4.0	552
Work satisfaction †	3.0 (± 0.6)	1.3-4.0	552
Task variation and opportunities †	2.8 (± 0.4)	1.4-4.0	552
Organizational commitment †	2.9 (± 0.5)	1.0-4.0	552
Teamwork †	3.0 (± 0.4)	1.2-4.0	549
Transformational leadership ‡	3.3 (± 0.9)	1.0-5.0	529
Unity in philosophy of care ‡	3.5 (± 0.9)	1.0-5.0	529
Person- centered care §	3.0 (± 0.4)	2.0-3.9	533

† Scale range 1: totally disagree to 4: totally agree
‡ Scale range 1: rarely or none of the time to 5: (almost) all of the time
§ Scale range 1: never to 5: always

Factors influencing person-centered care in nursing homes

Results of the multilevel analysis are reported in Table 4. A more transformational leadership style and a lower level of social support from the leader were significantly related to higher staff-reported person-centered care ($p \leq .001$ and $p \leq .05$, respectively). In addition, higher unity in philosophy of care ($p \leq .05$), higher levels of work satisfaction ($p \leq .001$) of direct care staff, more task variation and opportunities ($p \leq .05$) and better experienced teamwork ($p \leq .05$) were significantly related to higher staff-reported person-centered care. Furthermore, the covariate nursing assistant was significantly related to person-centered care ($p \leq .05$), meaning that compared to registered nurses, nurse assistants indicated that less person-centered care was provided. Work conditions, social support from colleagues and organisational commitment were not significantly related to staff-reported person-centered care.

Due to the significance level of .05, autonomy ($p \geq .05$) was considered non-significant, although the value of .054 was critical. The moderator analysis revealed that transformational leadership might have a moderating effect on the relationship between work conditions, autonomy, social support from the leader, organisational commitment, and higher unity in philosophy of care and staff-reported person-centered care.

Table 4. *Factors influencing person-centered care in nursing homes*

	B	SE	p-value
Work conditions	-.038013	.031476	.227
Autonomy	.074740	.038798	.054
Social support leader	-.095797	.030113	.001*
Social support colleagues	-.056112	.034930	.108
Work satisfaction	.126806	.033051	.000**
Task variation and opportunities	.100758	.037321	.007*
Organizational commitment	.043237	.034472	.210
Teamwork	.123065	.044665	.006*
Transformational leadership	.090501	.017093	.000**
Unity in philosophy of care	.045732	.014141	.001*
Certified nurse assistant	-.014456	.041851	.730
Nurse assistant	-.097823	.047358	.039*
Age	.001728	.000996	.083

Dependent variable: staff-reported person-centered care
*p < .05 is considered significant
**Statistical significance p < .001.

DISCUSSION

In this study, the association between work environment, job characteristics and staff-perceived person centeredness in nursing homes for people with dementia was assessed. Results indicated that work environment characteristics (i.e. transformational leadership, unity in philosophy of care, teamwork and three job characteristics [social support from leader, work satisfaction and task variation and development opportunities]) are associated with staff-reported person-centered care. Contrary to our expectations, no statistical associations were found for other job characteristics (work conditions, social support from colleagues, autonomy and organisational commitment) and staff-reported person-centered care.

The positive impact of leadership on person-centered care practices has been investigated earlier[16,39]. The positive association between leaders who follow a more transformational leadership style and staff-reported person-centered care can be explained by attitudes that are embodied by a transformational leader (see Box 1). In the literature, four components of transformational leadership are described that could be relevant to explain this association: idealized influence, individual consideration, inspirational motivation and intellectual stimulation[40-42]. A transformational leader who acts as a role model (idealized influence) experiences less resistance from staff towards change[43] and is likely capable of implementing interventions more easily, including those aimed at person-centered care. In addition, it has been reported that care staff has a desire to deliver person-centered care[44,45]. By empowering care staff

through individual consideration and inspirational motivation, a transformational leader can facilitate this preferred way of working.
Moreover, our results indicate that more unity in philosophy of care is associated with higher person-centered care. This is in line with earlier studies pointing out that communicating goals and visions are crucial for achieving high quality of care[19,46-48].
Another result of our study is that teamwork is associated with person-centered care. By enabling shared decision-making, positive and effective staff relationships have been found to be important in providing person-centered care in prior studies[49,50]. Other studies highlight teamwork as a key facilitator for providing person-centered care[51,52]. The nature of care tasks requires partnership and teamwork among caregivers[53]. Furthermore, effective teamwork provides more free time for caregivers to deliver person-centered care[52].
Higher task variation and opportunities, as well as work satisfaction, were also associated with staff-reported person-centered care. When care staff feels empowered and confident, they are more likely to work according to the wishes and needs of residents and experience more job satisfaction[54,55]. Prior studies also investigated the effect of person-centered care on job satisfaction among direct care staff. These studies show that a higher degree of person-centered care contributes to higher work satisfaction among nurses[44,56,57].
Our results show that less social support from a leader is associated with more staff-reported person-centered care. This could be explained by the assumption that teams who already perform more independently and provide high levels of person-centered care need less support from their leader. The theory of Tuckman and Jensen[58] suggests that groups who reached the fourth out of five development stages within a group forming process perform more independently and need less or even no support from a leader to reach a common goal. The association between social support from a leader, team performance and staff-reported person-centered care should be investigated more closely.
In our sample, the majority of participants were certified nurse assistants, followed by nurse assistants. This is a typical configuration for the Dutch long-term care setting, where vocationally trained or baccalaureate-educated registered nurses make up the lowest percentage of direct care staff[59,60]. In the Netherlands, certified nurse assistants follow a 2- to 3-year vocational training[61]. Nurse assistants are less educated and follow a 2-year educational programme[62]. Our findings show a negative association between nurse assistants and staff-reported person-centered care, as nurse assistants indicated that less person-centered care was provided. This could be due to a discrepancy of educational programs trying to enhance person-centered care. Overall, educational programs, such as training on the job, are aimed at staff from diverse occupations and educational levels[33]. Up to now, there is little evidence for long-term maintenance of knowledge gained by those training programmes[63]. Nurse assistants even report getting most of their knowledge through work-related experiences[33,64,65]. Furthermore, it has been reported that educational programs for nurse assistants in the Netherlands are not focused enough on providing person-centered care in elderly individuals[66]. This discrepancy between educational programs and actual knowledge gained in practice could explain a negative association between nurse assistants and provision of person-centered care. Further research is needed to investigate the relationship between the educational level of direct care staff and the provision of person-centered care in the nursing home setting.

Several limitations should be taken into account. Due to the cross-sectional design, we were only able to investigate associations and no cause–effect relationships. Therefore, our findings should be interpreted with care. A potential weakness may be that staff-reported person-centered care was measured on the basis of individual perceptions about their own performance and is therefore subjective. Additionally, it has been suggested that care staff are biased to give socially or politically correct answers about person-centered care[18].

CONCLUSIONS

This study has highlighted that transformational leadership, unity in philosophy of care, teamwork and three job characteristics (social support from leader, work satisfaction and task variation and development opportunities) are associated with staff-reported person-centered care. Future longitudinal studies could provide more insight into these relationships. Person-centered care could be improved by generating more evidence on the cause–effect relationships of work environment characteristics and person-centered care. Additionally, future research may investigate which components of transformational leadership are associated with more person-centered care behavior in care staff. To facilitate person-centered care in nursing homes, it seems beneficial to train leaders to follow a more transformational leadership style.

IMPLICATIONS FOR NURSING MANAGEMENT

The results highlight that in a complex environment such as a nursing home, a diversity of factors is associated with the desirable client outcome of person-centered care. Within the nursing home, relationships and collaboration play an important role. To achieve unity in philosophy of care and shared values, a collaboration between leaders, care staff, clients and family members is recommended. Leaders may consider facilitating collaboration by frequent evaluation, implementing teambuilding interventions (e.g. coaching) to strengthen teamwork within care teams and active involvement of clients and family members.

To effectively fulfil these tasks, leaders may use a transformational leadership style. They could consider follow educational programs to learn about facets and characteristics of a transformational leadership style and could take part in learning communities to reflect on actions and their effect. This may enable them to balance interests of all parties involved in the nursing home, to work in a relationship-centered way and to facilitate person-centered care.

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CHAPTER 3

Working in a Dutch nursing home during the COVID-19 pandemic: Experiences and lessons learned

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ABSTRACT
Aims: To gain insight into how direct care staff in Dutch nursing homes experienced work during the COVID-19 pandemic.
Design: A qualitative study consisting of semi-structured, face-to-face focus groups was conducted using "the active dialogue approach"
Methods: Participants (*n* = 29) were care staff from four care teams at Dutch nursing homes. Teams were selected based on the number of COVID-19 infections amongst residents. Data were analyzed with conventional content analysis.
Results: Themes emerging from the data were the loss of (daily) working structure, interference between work and private life for direct care staff, the importance of social support by the team and a leader, and the effects on relationship-centered care of the measures. Results offer concrete implications for similar situations in the future: psychological support on-site; autonomy in daily work of care staff; an active role of a manger on the work floor and the importance of relationship-centered care.

INTRODUCTION

Older people living in nursing homes seem to be at particular high risk of severe courses of COVID-19 and seem to suffer from an increased related mortality.[1] First, estimations from European countries suggest that between 19% and 72% of all people who died from COVID-19 lived in a nursing home.[2,3] At this moment, the COVID-19 pandemic is still ongoing. To prevent and reduce the number of infections, nursing homes have taken very restrictive measures that have changed the way of living and working in nursing homes. Examples are bans on visitors and volunteers, isolation of residents, reduced contact time between residents and direct care staff, as well as restrictions or bans of medical and allied health professionals.[4] Nevertheless, as of 27 October 2020, estimations of electronic resident files indicate that 15,987 residents in Dutch nursing homes (had) suffer(ed) from (suspected) COVID-19, of which 2,219 residents have died and 3,154 have recovered.[5] In addition, direct care staff members who spend much time with infected residents, often without wearing personal protective equipment (PPE), have also become ill or have died. In the Netherlands (until October 2020), 18% (total number 34,376) of the persons infected with COVID-19 and 1.8% (total number 14) of COVID-19 fatalities were reported to be care staff.[6]

In March 2020, the World Health Organization (WHO) recommended that healthcare workers should not only wear PPE but should also be properly trained in how to put it on, remove it and dispose of it.[7] At the beginning of the pandemic, there was a critical shortage of PPE for front-line healthcare workers due to several reasons, such as problems within the global supply chain.[8] The shortage led to the use of lower-grade equipment or even the reuse of equipment, which put care staff at higher risk for getting infected.[9]

BACKGROUND

The long-term consequences for those who live and work in nursing homes are yet to be unveiled, and few studies on primary data exist. Anecdotal knowledge about current nursing home care provision suggests that direct care staff had to find a balance between restrictive infection control measures and the delivery of person- or relationship-centered care to maintain residents' social participation and well-being.[1] In 2020, care provision in nursing homes is ideally relationship-centered, which implies that the needs of the resident, the family and the needs of the care staff are taken into account.[10,11] The applied measures to prevent CODVID-19 infections violated the principles of relationship-centered care, as they put safety above individual needs. This not only had consequences for the residents who experienced loneliness and social isolation but also for care staff who wanted to provide personal and individual care to the residents.[12] The dilemma of safety versus quality of life which care staff experiences in nursing homes has been reported before.[13] Additionally, immense psychological burdens due to a mix of workplace stressors and personal fears affect care staff's well-being.[14]

As staff in direct care had little time to prepare for the pandemic and had to adapt to changes in their way of working quickly, the long-term mental and physical impact on staff is expected to be huge. More than ever, long-term care organizations are being forced to invest in the health and well-being of their employees. It is well-known that direct care staff are in the "line of fire" and play a key role in facing the pandemic.[15] First indications from hospital settings highlight the impact of the pandemic on the employment and the mental health of the direct care staff and the quality of care.[16,17] To enable staff to stay healthy, keep them at work and support their well-being, organizational and governmental support (e.g. a clear testing policy, sufficient PPE and employment conditions) seem indispensable. To guarantee the sustainable employment of direct care staff, it is important to have an understanding of the work-related issues which they face during the COVID-19 pandemic.

The aim of this study was to provide insight into how staff members experienced work during the pandemic.

METHODS

Study design

In June 2020, a qualitative study was conducted in which data were collected by means of focus groups using "the active dialogue approach".

Participants and research context

Participants were employees from four different teams located at three nursing homes that are part of a Dutch long-term care organization. All team members were verbally invited by their team manager to participate. Participation was voluntary and was held during their working hours.

Nursing homes in the Netherlands provide long-term residential care for people with dementia and/or severe physical disabilities and short-term skilled care for rehabilitation or subacute conditions.[18] The educational level of direct care staff varies. Most care is provided by certified nurse assistants (CNAs), with 2–3 years of education. These CNAs are comparable to licensed practical or licensed vocational nurses in the United States.[19] In addition, there are also nurse assistants or nurse aides, as well as some uneducated staff members. Often, the lowest percentage of care is provided by vocationally trained or baccalaureate-educated registered nurses.[20] Unique to the Netherlands, nursing home medical specialists provide medical care for nursing home residents. These medical specialists as well as all associated health professionals (e.g. physiotherapists, psychologists, occupational therapists) are employed by the nursing home.

During the lockdown period in the Netherlands, nursing homes applied several measures to prevent COVID-19 infections.[3] Examples are as follows: visitors were not allowed access, direct care staff was not allowed to switch between wards and residents were not allowed to leave their ward, infected residents were isolated in their own room (except for residents with dementia), group activities were disallowed if the 1.5 m distance rule could not be kept and new residents were isolated until they were free of any symptoms.

Teams were selected by using a purposeful sampling method.[21] Based on the number of COVID-19 infections among residents, the healthcare organization selected four teams. In the ward shared by two teams, no residents were infected, while in the other two wards many residents got infected and died. In Table 1, the participants of each team are described.

Table 1: Team characteristics

Team	CODIV-19 infections	Participants
Team A	No infections	Four certified nurse assistants
		One baccalaureate-educated registered nurse
		One manager
Team B	COVID- 19 infections	Four certified nurse assistants
		One vocationally trained registered nurse
		One occupational therapist
		One manager
Team C	COVID- 19 infections	Two certified nurse assistants
		One baccalaureate-educated registered nurse
		One vocationally trained registered nurse
		One nurse assistant
		One activity staff member
		Job title not reported
Team D	No infections	Four certified nurse assistants
		Three vocationally trained registered nurses
		One manager

Data collection

Data were collected by means of four semi-structured face-to-face focus groups in June 2020. A topic list based on the principles of the active dialogue technique developed by ZozorgIk was used to structure the focus groups (Table 2). This technique focuses on participants sharing experiences within a dialogue. The underlying philosophy of the active dialogue approach is appreciative inquiry. Within appreciative inquiry, people are engaged to produce effective and positive change.[22] Questions asked during the dialogue were equal for all participants and the participants were able to determine the main content of the discussion.

Table 2: Guiding questions

1. Introduce yourself: who are you and which photo did you pick and why?
2. What have been your personal experiences during the COVID-19 pandemic?
3. Which event touched you the most?
4. Looking back at the past months, what do you wish for the future?
    a. Is there something you would like to keep for the future?
    b. Did you learn something new (for instance a new way of working or an innovative idea)?

Two independent professionals (first author and an external team coach) organized the focus groups that lasted on average 120 min and took place at the nursing home location. The team coach led the discussion, and the researcher took detailed notes and verified that all topics were covered. After the session, the notes were sent to the participants for a member check.[23] Additional remarks of respondents were included in the notes. Detailed notes were preferred over audiotapes to ensure a safe atmosphere for the participants.

To start the dialogue, a photo elicitation technique[24] was applied in which participants had to select one or two photos (out of 50) that best reflected their experience during the COVID-19 pandemic. Examples were photos of a beach, a rollercoaster, a mule, a sunflower, an orange fruit, a candle or a soccer team. The idea behind using photo elicitation in interviews is that the participants are likely to respond differently when using images instead of only words. When triggered to combine images and words, respondents are more likely to unveil their true views and beliefs.[24,25]

Data analysis

Data analysis was based on the detailed notes gathered in all four focus groups. In the analysis, respondents' explanations of why they chose specific photos were analysed. Conventional content analysis was used to acquire a descriptive presentation of the qualitative data.[26] This is a systematic approach to code and categorize qualitative data to determine trends and patterns.[27,28] Content analysis is reported to be well suited to analyse multifaceted phenomena in nursing.[29,30]

By reading the notes multiple times, the authors gained a deeper understanding of the data. The first author identified key concepts by means of open coding. These codes consisted of a few words or short sentences. The emerging concepts were summarized in a code tree and the codes were then integrated into central topics. The code tree and the central topics were discussed within the research team. Differences were resolved and adjusted throughout the whole process of data analysis. The data were analysed with MAXQDA version 20.0.8 software.[31]

Rigour

Different strategies were applied to enhance study rigour. Due to purposive sampling, the views of staff members of teams that differed with regard to the number of COVID-19 infections among residents could be compared.[32]

Space triangulation (i.e. data collection among teams working in different sites to test for cross-site consistency) led to richer insights into the research topic.[33] Verification by participants was reached through a member check. The coding process and clustering of data were cross-checked within the

research team, leading to a refinement of the coding frame.[32] The COREQ (COnsolidated criteria for Reporting Qualitative research) Checklist was used.[34]

Ethical considerations

According to Dutch law, approval from an ethics committee was not needed, as no residents were involved (http://www.ccmo.nl/en/your-research-does-it-fall-under-the-wmo). Verbal and written consent for participation were obtained before the focus groups took place. At the start of each focus group, the researchers emphasized that participation was voluntary and that all answers would be treated with strict confidentiality. Respondents received an information letter and were able to withdraw at any time. All respondents signed the informed consent; there were no withdrawals. No audiotapes were made and all data were analysed anonymously.

RESULTS

In total, 29 care staff from four different teams located in three nursing homes participated in the focus groups (Table 3).

Table 3: Participants' characteristics (n=29) †

Demographic characteristics	
Age in years (mean/range;)	44 (22-63)
Gender: female (n; %; n=29)	24 (83%)
Experience as informal care staff in a nursing home (n, %)	9 (33%)
Occupational characteristics	
Years of experience in current position (mean/range)	17 (1-45)
Direct care professionals (n):	24
- Nurse assistant (n)	1
- Certified nurse assistant (n)	14
- Vocationally trained registered nurse (n)	5
- Baccalaureate-educated registered nurse (n)	2
- Activity staff (n)	1
- Occupational therapist (n)	1
Nursing home managers (n):	3

† Two participants did not provide information on demographic or occupational characteristics.

The results of the photo elicitation highlighted the variety of experiences during the COVID-19 lockdown. The chosen photos showed that each team experienced the lockdown in a different way depending upon the situation on the ward. Participants from wards without infections mainly selected photos that expressed positive feelings, such as hope, closeness and taking care of each other. For example, one participant selected a photo of a beach because the past weeks felt like a vacation, her way of working did not change and, in her ward, it was quiet, "while in the rest of the world it was the opposite". Participants working on wards with COVID-19 infections experienced the opposite. They mainly selected negatively associated photos, such as the photo of a mule (as the pressure at work got higher and higher and the participant felt like a "fully packed mule").

From the conventional content analysis, four major themes emerged that dealt with how participants experienced work during the pandemic and how their way of working had changed (Table 4): loss of (daily) structure, work and private life interference, social support and relationship-centered care.

Table 4: Identified themes related to staff's care experiences during the lockdown

Theme	Subtheme
Loss of (daily) structure	Degree of experienced stress
	Administrative tasks
	Top-down decision making
Work and private live interference	Fear for infection
	Social contacts
	Taking home stress from work
Social support	Teamwork within wards
	Collaboration between different teams
	Social support from a leader
	Psychological support
Relationship centered care	Effect of measures
	Loneliness of the clients
	Providing High quality of care
	Collaboration with the family

Loss of (daily) structure

Regarding the loss of daily structure and routines, participants mentioned that there was an overall reduction in administrative tasks and an increase or decrease in the level of stress, depending on whether there were infected residents on the ward. During the lockdown, a majority of administrative (often mandatory) tasks were no longer necessary or allowed, for instance team meetings or training. All participants reported that they perceived that they had more time for one-on-one activities with the residents (e.g. more attention to personal hygiene or individual conversations). They suggested for the future to minimize the number of administrative tasks in order to reserve more time to spend with the residents and for primary care delivery tasks. Furthermore, participants proposed organizing short, informal evaluation moments instead of mandatory large-scale team meetings. During the lockdown, the short evaluation moments were considered effective and an improvement in the quality of work.
Participants who worked on wards without infected residents experienced a quiet and peaceful atmosphere. They felt that the peaceful atmosphere on their ward was in contrast to the hectic COVID-19 related events outside the nursing home. In addition, they reported to have more time to spend with the residents. Some participants mentioned that residents with dementia were less agitated, which resulted, according to them, in lower administration of psychotropic drug use.
Participants working on wards with infected residents experienced a stressful period. The loss of daily structure, ambiguous communication about new measures and additional tasks, such as wearing protective equipment and top-down decision-making, contributed to a stressful work atmosphere. The new measures and restrictions caused a loss of structure and daily routines. On top of that, the

frequency of new measures and communication (for instance via e-mail) about the application of these measures caused insecurity and uncertainty. One participant expressed that the measures and guidelines changed so quickly that this caused confusion among the care staff. Communication about new measures and guidelines took place via e-mail, without the opportunity to ask particular questions, which caused insecurity.

"Everybody [of the team] *gets the same e-mail* [with instructions] *and it* [the rules and measures] *is still unclear."* (Participant of team C)

Participants also expressed that in order to integrate new measures and guidelines in the most fitting way into their daily work processes, they wanted to be part of the decision-making process. According to them, new measures and guidelines would then be less disturbing. They felt this would make the application of new measures and guidelines more efficient and comprehensible for direct care staff.

Work and private life interference

Regarding work and private life interference, participants reported that a fear of infection, social isolation and loneliness, and an increase in stress were factors that had a significant impact on their personal and working lives. All participants mentioned that they had taken home stress from work. Additionally, they reported that they had even fewer social contacts than others in society due to their awareness of the possibility of bringing the virus into the nursing home. Participants reported that they were afraid of getting infected or of infecting others, such as relatives or residents.

"*My husband was looking at me, and I saw in his eyes that he blamed me for making him sick—he wouldn't say it, but I saw it*." [Participant with a husband who had COVID-19] (Participant of team C)

The fear of infection caused participants to avoid even more social contacts compared with others which made them feel lonely. Not being able to meet with relatives, such as grandchildren, caused loneliness and social isolation. One participant reported she was so terrified that she locked herself up in her home. Specifically, participants working on wards with infected residents reported they were not able to leave the stress behind when returning home. Some participants had so much difficulty relaxing in their free time that it caused exhaustion.

"After the last one died, we thought 'now we can finally sleep again'." (Participant of team C)

Social support

Regarding the topic of social support, participants mentioned improved teamwork within teams, a decline in collaboration between teams, lack of support from leaders and insufficient aftercare.
All participants mentioned that the teamwork within teams improved notably. The lockdown strengthened mutual trust and team members supported each other "more than usual". The existence of a common goal ("to be there for lonely residents") tied the team members together even more.

"Penguins are animals with a positive attitude, but with difficulties to walk and that is how I experienced the past weeks. The team had a good attitude, but a lot of challenges to deal with." (participant of team D)

Participants also highlighted the importance of good communication, evaluation and giving feedback within the team and mentioned that these aspects improved greatly. They wished to keep up the spirit of teamwork and to implement more frequent and less formal evaluation moments to provide feedback to each other.

"Due to COVID-19, it was even more important to communicate with each other, and this therefore improved. It was kind of mandatory to listen to tips from others; to survive as a team it was necessary to have evaluation moments." (Participant of team D)
In contrast to the improved teamwork within teams, collaboration between different teams declined. Teams experiencing higher work pressure missed the support of other teams and teams working on wards with infected residents felt abandoned by other teams.

"The pressure at work got higher and I felt like a fully packed mule the past weeks. We got more and more tasks and received no help from other colleagues of other wards." (Participant of team C)

Additionally, two of the four teams reported a lack of social support from leaders in the crisis situation and a lack of suitable "aftercare". Here, participants distinguished between their team leader and higher management. The (physical) absence of a manager, in charge of implementing and deciding on new measures, caused the feeling of being alone in the crisis situation for participants. The team leaders, in general, supported their teams sufficiently, but participants desired more (personal) attention and appreciation from the higher management.

"*They* [the higher management] *had to be present at the ward, wearing personal protective equipment*." (Participant of team C)

Participants were given the opportunity to schedule an online or telephone consult with an internal psychologist for support during the pandemic. According to them, a "remote psychologist" (the organization provided a psychologist – employed at the organization – on call for direct care staff for which appointments had to be scheduled) was insufficient. Undertaking the step to call for an appointment was considered a barrier to making use of the consult. Participants expressed the need for on-site psychological support to ask for help in the moment. Furthermore, they highlighted the need for someone they could talk to about their feelings. According to them, timely support on demand instead of an appointment scheduled for a week later was important.

Relationship-centered care

Regarding the topic of relationship-centered care, the following points were reported: the impact of the applied measures, loneliness of the residents and collaboration with the residents' families.
Participants expressed their concerns regarding the applied measures, in particular the ban of visitors. They implied that this increased loneliness and restricted decision-making for residents. According to the participants, the applied measures were focused on safety and did not take into account the importance of relationship-centered care. Residents had no opportunities to express their personal wishes and needs, for instance if they chose to see their family members instead of choosing safety. All relationships outside the nursing home and sometimes even inside the nursing homes were cut off. For participants, this felt like a restriction in offering the best quality of care. In order to provide the best quality of care, participants felt they sometimes needed to violate the rules:

"If we had followed all the rules, we would have been very inhuman—then we would have suffered from our behaviour." (Participant of team B)

In cases where residents died, participants especially felt the restrictions due to the COVID-19 measures. Only a limited number of visitors were allowed to see a resident on their last day of life, forcing care staff members to choose which family members were allowed to say their final goodbyes. In addition, direct care staff themselves and other residents were not able to say their final goodbyes to the residents in the usual way. They indicated that when a resident died, they missed the process of closure and that was the most radical event during the lockdown for them. They highlighted the importance of the process of closure for themselves, other residents and the family members.

"Three people were immediately put in a coffin without a chance for the family to say goodbye." (Participant of team C)

Due to the imposed measures, residents had no (physical) contact with their family and only restricted physical contact with their care providers. This caused loneliness among the residents. The experienced loneliness of the residents also greatly impacted the direct care staff. Staff perceived that loneliness worsened symptoms and increased the illness of some residents (e.g. decline in mental abilities). In general, the absence of physical contact with the direct care staff and family members was indicated as a cause of decline in mental abilities, especially for residents with dementia. Participants highlighted that they tried to offer the "best quality of care", while working under exceptional circumstances and seeing the residents suffering from either coronavirus disease and/or loneliness.
"*We didn't just commit 100% of ourselves, but 200% for the residents—this shines a bright light onto the past period*." (Participant of team A)

"Due to Covid-19, I did not only see loneliness but also closeness. The nurses took good care of the residents." (Participant of team A)

During the lockdown, family members who were not allowed to visit the nursing homes expressed their appreciation by sending the care staff gifts and cards. Participants appreciated the positive feedback and expressed their wish to strengthen the interaction with family members. According to the participants, a positive outcome was the quick adoption of new ways to involve family members (e.g. video calls).

DISCUSSION

This study aimed to gain insight into how direct care staff in Dutch nursing homes experienced working during the COVID-19 pandemic. All staff experienced a conflict between their role as a healthcare professional and a person in private life. Relationship-centered care played a crucial role, as staff members did their best to provide individual care and personal attention for residents, but this sometimes conflicted with rules and regulations of infection prevention. All participants mentioned that teamwork within teams improved notably. Findings showed that experiences differed for teams due to the presence or absence of COVID-19 infections on the wards. The loss of daily structure, combined with ambiguous communication about new measures, additional tasks such as wearing protective equipment and top-down decision-making contributed to a stressful work atmosphere. Staff without infections perceived more autonomy and felt they had more personal time with residents due to less administrative tasks.

Findings showed that care staff experienced a conflict between their professional roles and private lives. These conflicts appeared to be an additional burden and potentially contributed to a loss of a balanced life in a study among nurses working with COVID-19 patients in a clinical setting.[35] In our study, care staff felt particularly afraid of infection and felt stressed. Severe mental health issues, such as stress, anxiety, anger and insomnia resulting from the loss of a balanced life, have been reported earlier for care staff working with COVID-19 patients.[36,37]
Care staff members working on wards without COVID-19 infections experienced more autonomy due to fewer administrative tasks and therefore enjoyed working more than usual. They described their daily work as more "peaceful" and enjoyed being able to spend more (one-on-one) time with the residents. Autonomy, defined as the choice between alternate actions[38], has been associated with higher overall job satisfaction for care staff in clinical practice.[39] In addition, being able to provide person-centered care by knowing the patient well has shown to promote care staff acting more autonomously in their daily work.[40] Knowledge about the patient and the relationship with patients seem important to develop professional autonomy.[40,41]

The possibility to get to know the patient seems to give the nurses in this study invaluable knowledge and a greater opportunity to act autonomously and create holistic care both towards an individual patient and groups of patients.
As a consequence of the unusual circumstances, teams reported a better teamwork within teams, but less collaboration between teams. Results of a German study reported that teamwork was a good motivator for care staff to continue working during a crisis.[42] Our findings highlight the importance of good functioning teams. Short and unofficial evaluation moments within teams to reflect on the current situation and to solve problems supported teams in their work during the pandemic.
Participants stressed their wish for support and clinical leadership. With respect to their manager, they expected the manager to be physically available, make decisions, "feel" what it means to work during the pandemic and appreciate their work. Moreover, direct care staff emphasized that they need support "at the moment when a critical situation arises". "Remote" psychological support was considered insufficient. McGilton et al.[43] recommended for the nursing home setting in a pandemic, among others, more 1:1 engagement between supervisors and staff, with an emphasis on appreciation of the work being done, to develop a leadership group that is available 24 hr a day to support staff and to ensure that at least one manager is physically present to address questions. Tan, Abhiram, et al.[44] concluded, based on a qualitative study involving nurses in Wuhan, that it is necessary to strengthen the availability of personalized psychological interventions for front-line nurses. An editorial by Williamson et al.[45] highlights the need for "readily accessible psychological support" for care staff. They blame waiting lists as a reason why care staff do not seek psychological support at all.
The perceived loneliness of residents was a trigger for direct care staff to deliver more personalized care, such as individual conversations and one-on-one activities. While earlier research has already indicated that for direct care staff preventing residents' loneliness is as important as personal hygiene[46], they now felt hampered by the restrictive measures and did their best to deliver person-centered care during the lockdown. An earlier study reported that care staff experienced a discrepancy between following rules and offering the best quality of care during the COVID-19 pandemic.[42] In addition, care staff highlighted that collaboration with the residents' families is important in times of a pandemic. Taking into account the needs of the resident who lives in the nursing home, the family who visits and the care professional who works in the nursing home belongs to the concept of relationship-centered care.[47,48] In past years the concept of relationship-centered care has become a central concept in the long-term care sector.[49] Several benefits of relationship-centered care have been reported: higher quality of life for the residents, more successful clinical interventions, higher satisfaction for care staff and residents and lower mortality.[50-52] Therefore, it seems especially important to keep up relationship-centered care during a pandemic, as it benefits all stakeholders in the nursing home setting.

Several methodological considerations need to be addressed. Focus groups were held with four teams from one healthcare organization in the south of the Netherlands; therefore, this study might not be representative of other teams in the Netherlands. Due to the sample size, it is hard to assess whether data saturation has reached. In order to achieve data saturation, a member check took place in which participants had no additional comments on the data. Purposeful sampling, was used to select extreme cases to enrich the data. Teams were, however, chosen by the healthcare organization, so it is unknown if any selection bias, in the sense of intentionally not inviting specific teams, has occurred. The discussion leader invited all participants to report their opinions by directly asking them. Nevertheless, their participation during the following group discussions differed. Furthermore, the presence of the team manager in three of the four focus groups might have led to socially desirable answers from the participants. In one focus group no team manager was present and participants seemed to be more negative about the management and leadership style.

At the moment, it is still unclear how long the COVID-19 pandemic will continue. Based on our results, it is recommended that the interests of all parties within the nursing home setting should be considered. To ensure a healthy work environment and care quality, it is recommended to evaluate these on a regular basis.

For direct care staff, straightforward communication and autonomy in their way of working and implementing on-site psychological support in crisis situations is recommended. Managers with decision-making authority should be actively involved on the work floor and offer care staff the opportunity to work as autonomously as possible. Residents' personal needs and wishes should be considered in decision-making processes. Family members should be involved instead of locked out, and collaboration should be strengthened by considering their needs. Our results highlight the importance of a continuous evaluation of the working situation for care staff during a pandemic.
Further research should investigate practical ways for sustainable employment and empowerment of direct care staff in nursing homes. Barriers to and facilitators of job satisfaction and stress levels in a pandemic should be investigated. Additionally, the methods and the effectiveness of psychological and managerial support, especially in crisis situations, should be investigated.

CONCLUSION

To date, this is one of the first studies that has collected experiences of direct care staff working in nursing homes in the Netherlands during the COVID-19 lockdown. Nursing home care staff experienced a turbulent period from which a lot can be learned for similar situations in the future: psychological support should be on-site, care staff appreciate autonomy in their daily work, the active role of a manger on the work floor is important and relationship-centered care becomes even more relevant and should not be hampered by guidelines or measures. It is therefore important to find a balance.

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CHAPTER 4

Listen, look, link and learn: a stepwise approach to use narrative quality data within resident-family-nursing staff triads in nursing homes for quality improvements

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ABSTRACT

Purpose: The use of qualitative data to assess quality of care in nursing homes from the resident's perspective has shown to be valuable, yet more research is needed to determine how this data can be used to gain insight into the quality of care within nursing homes. Whereas it is crucial to stay close to the stories that are the strength of qualitative data, an intermittent step to classify this data can support the interpretation and use. Therefore, this study introduces an approach that enables the use of narrative quality of care data to learn from and improve with.

Design: A cross-sectional mixed-methods study in which qualitative data was collected with the narrative quality assessment method 'Connecting Conversations' and interpreted for analysis.

Methods: 'Connecting Conversations' was used to collect narrative data about experienced quality of care in nursing homes according to residents, their families and nursing staff (triads). Data analysis consisted of coding positive/negative valences in each transcript.

Findings: A stepwise approach can support the use of narrative quality data consisting of four steps: (1) perform and transcribe the conversations (listen); (2) calculate a valence sore, defined as the mean %-positive within a triad (look); (3) calculate an agreement score, defined as the level of agreement between resident-family-nursing staff (link); and (4) plot scores into a graph for interpretation and learning purposes with agreement score (x-axis) and valence score (y-axis) (learn).

Conclusions: Narrative quality data can be interpreted as a valence and agreement score. These scores need to be related to the raw qualitative data to gain a rich understanding of what is going well and what needs to be improved.

INTRODUCTION

Care provision in nursing homes has experienced a shift from being merely task-centered to being more relationship-centered, in which not only the resident's needs, but also family and nursing staffs' needs are considered.[1-3] This has resulted in a new view towards quality of care in nursing homes known as experienced quality of care. Experienced quality of care is a process that is influenced by expectations; interactions and relationships between the resident, family and nursing staff; and an assessment afterwards.[4] Residents, family and nursing staff in the care process each have their own needs and aspects they consider important regarding receiving and providing high quality of care, which can differ from each other.[5,6] As service receivers, residents have expressed the importance of the nursing home environment, maintaining personhood; having and maintaining meaningful relationships with staff, family and other residents, and receiving tailored care.[7] Residents and family have expressed the importance of feeling at home in a nursing home [8]. In addition, family values personalized attention for residents, recalling who they used to be, and receiving the opportunity to take some own responsibility in the care for the resident.[5,9] As service providers, nursing staff often base their judgement of experienced quality of care on their task priorities, such as delivering personal individual care, creating a nice and friendly atmosphere and supporting residents emotionally.[10] Furthermore, understanding residents' behaviors is important to them.[5] By including these three different perspectives, discrepancies can be identified and a better understanding of the care experiences can be established, which assures that integral quality improvement plans are focused on the correct elements and enhances support to realize these improvements.[11,12]

Up until recently, experienced quality of care was mostly assessed with questionnaires, such as the CAHPS-NH.[13] Research however has shown that whereas quantitative data is informative for some purposes, it misses the meaning behind a rating, providing insufficient information to determine what exactly is going well and what needs to be improve.[14] Therefore, narrative methods have shown to be a powerful complementary method to discover what residents, families and nursing staff value, and to evaluate and improve care services based on their experiences.[15,16] These narratives capture an experience by providing information about the caring relationships, explaining rationales and possessing emotions.[17] 'Connecting Conversations' is a narrative method that assesses experienced quality of care by performing separate conversations with the three actors in the care triad.[18] It identifies similarities and discrepancies between residents', families' and nursing staffs' experienced quality of care and is based on the principles of relationship-centered care. In addition, appreciative inquiry is used to discover positive routines within nursing homes, i.e. what is going well.[19]

Whereas 'Connecting Conversations' has shown to be feasible and valid to assess experienced quality of care in nursing homes, there is still a need to improve the usability of the narrative data for quality improvements. Merely assessing experienced quality of care is not sufficient as it is indispensable that the information can be used in practice for learning and improvement purposes.[14] There is a need to discover how to use narrative data in practice, as the data are very rich and analysis is considered very time-intensive.[20,21] Ideally, narratives are interpreted and classified into usable information to learn from and that can contribute towards improving quality of care. Therefore, this study aims to introduce a stepwise approach that enables the use of narrative data collected with 'Connecting Conversations' to acquire an interpretation of the data that can assist with initiating quality improvements.

METHODS

Study design

In this cross-sectional mixed-methods study, qualitative data were collected with 'Connecting Conversations' and quantified for analysis. Data was collected during autumn 2018 within the Living Lab in Aging and Long-Term Care in the south of the Netherlands.[22]

Setting and participants

'Connecting Conversations' was executed in 5 care organizations in the south of the Netherlands, including somatic wards, for older people with physical disabilities, and psychogeriatric wards, for older people with dementia (24 full care triads included). Random selection of residents on a ward was performed by generating a random sequence list of residents' room numbers of the ward and inviting the first five residents to participate.[18] This ensured equal opportunity of participation for all residents on the ward, regardless of their diagnoses, capabilities and personalities. After a resident agreed to participate, a closely involved family member and a caregiver that provided care to the resident at least once a week were invited to participate as part of the care triad.

Data collection

Demographic characteristics were collected for the care triads (residents, family and professional caregivers) by the interviewer. For residents, age in years, sex, months living in the nursing home, activities of daily living (ADL) assessed with the ADL-scale (range from 0 independent to 6 fully dependent) and cognitive functioning assessed with the Cognitive Performance Scale (CPS, range from 0 full cognitive functioning to 6 extremely limited cognitive functioning) were collected.[23] For family, age in years, sex, relationship to resident, and hours of weekly employment were collected. For caregivers, age in years, sex, and hours of weekly employment were collected.

Data were collected with the narrative assessment method 'Connecting Conversations', which assesses experienced quality of care in nursing homes as defined by the INDEXQUAL framework, by separately interviewing residents, family and nursing staff (care triad), adopting an appreciative inquiry approach. The 'Connecting Conversations' interview guide consisted of six questions to trigger respondents to share what matters to them. Questions 1 and 2 are about on the resident's quality of life and satisfaction with caregivers, asking to grade these and hereafter elaborating on what is needed to increase these grades. Hereafter, participants are asked to tell about the most positive experience in the nursing home, about an average day in the nursing home and about relationships between the resident, family and caregivers. Family and nursing staff were asked to answer the questions from the resident's perspective. The inclusion of three actors within a triad is considered a form of data triangulation.[24] Interviewers were nursing staff employed at another nursing home. They received a three-day 'Connecting Conversations' training in which they learned to perform separate interviews with residents, their family and professional caregivers. The interviews were audio recorded and summaries to each question were documented on a tablet. Full details on 'Connecting Conversations' have previously been published.[18]

National experts in nursing home policy and practice (n=11), provided advice on the content and format of the stepwise approach during two expert panel meetings, to enhance suitability for practice.

Data analysis

Data analysis was performed for all 24 fully completed care triads available with audio-recordings.[18] Figure 1 presents the steps in analysis: listen (collecting data), look (understanding data), link (analyzing data) and learn (using data).

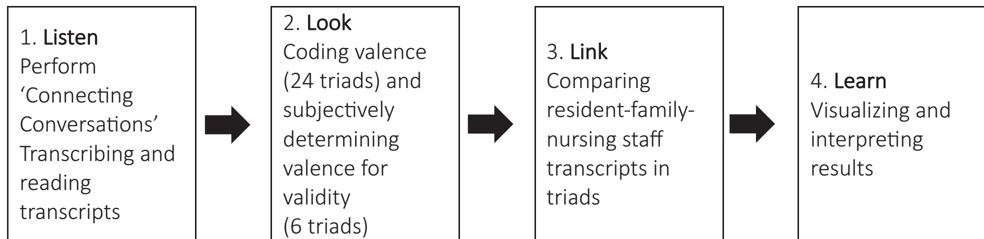

Figure 1. Analysis steps

As a first step to interpret the data as a quality rating, it was important to gain insight into what the conversations were truly about. Therefore, first, the interviews were transcribed verbatim by three members of the research team and read multiple times. Second, all 72 transcripts (24 triads) were coded with two codes: positive or negative. Coding was performed by one researcher and checked by another researcher. When disagreements occurred, a third researcher was consulted and coding was discussed until consensus was reached. Only pieces of text that were dependent on the process of care service delivery and the environment of the nursing home with a clear valence expressing a positive or negative experience were coded (hereafter called segments). For example, "I like the food here" or "the resident enjoys family visits" were coded as positive, as these aspects were made possible by the nursing home and the words *like* and *enjoy* express a positive valence. Descriptions of the relationship between the resident and family, such as "I have a good relationship with my daughter" or about the who the resident is "She is lucky she can still walk and is not in a wheelchair" were not coded, because these are not directly related to the service delivered by the nursing home. In addition, neutral segments without a valence expressing if someone was positive (satisfied) or negative (dissatisfied) were not coded, such as "I get showered twice a week". To validate the coding with positive and negative segments, for 6 triads (25%) the researchers determined if the transcripts were overall considered positive or negative as a comparison to the coding. The research team also explored how to translate the ratio of positive/negative valences into a valence score, defined as a score ranging from a transcript being very negative to very positive, based on the amount of coded segments. Third, the research team explored possibilities to determine a level of agreement between the resident, family and nursing staff. Agreement was defined as the coherence between individual resident-family-nursing staff triads, dependent on the positive or negative valence score. Agreement did not take into consideration the content of each transcript, thus only the agreement between being negative or positive. As a final step, possibilities to visualize the analyzed data for interpretation and learning purposes were explored. Qualitative analyses were performed with the software package for qualitative data analysis MAXQDA v20.0.8 and quantitative data analysis were performed in MS Excel v2016.[25,26]

Ethical considerations

The Medical Ethics Committee of Zuyderland (17-N-86) approved the study protocol. Participants received information about the purpose of the study at least two weeks before the interview and submitted written informed consent. Participants could withdraw their voluntary participation at any moment. For residents living on psychogeriatric wards, the legal representative provided informed consent for their participation and during the interviews residents provided informed assent. To guarantee confidentiality of the interviews, no names or locations were documented.

RESULTS

In total, 24 triads were included for analysis, in 8 nursing homes, of which 8 psychogeriatric wards, 4 somatic wards and 1 acquired brain injury ward (Table 1).

Table 1. Demographics care triads

Resident (N=24)	Mean age in years (min-max)[a]		80 (43-95)
	Female (%)		17 (71%)
	Mean months in nursing home (min-max)[b]		31 (2-180)
	Mean ADL (min-max)		3.1 (0-6)
	Mean CPS (min-max)		2.9 (0-6)
Family (N=24)	Age in years (%)[b]	45-54	5 (23%)
		55-64	11 (50%)
		≥ 65	6 (27%)
	Female (%)		16 (67%)
	Relationship to resident (%)	Child	16 (67%)
		Parent	3 (12%)
		Partner	2 (8%)
		Niece	2 (8%)
		Sibling	1 (4%)
	Mean employment hr/wk (min-max)[c]		11.5 (0-40)
Caregiver, professional (N=18) *	Mean age in years (min-max)		40 (24-62)
	% Female		17 (94%)
	Mean employment hrs/wk (min-max)		29 (24-36)
	Mean years working in nursing home (min-max)[d]		12 (1-31)

[a] N=21, [b] N=22, [c] N=20, [d] N=17, *several caregivers were interviewed for multiple care triads

Narratives collected with 'Connecting Conversations' (listen)

In each conversation, there were emotional and/or judgement words used, suggesting that care experiences are indeed expressed with positive and/or negative loaded words. In addition, similarities and/or differences between the valences of residents, families and staffs were recognized. To portray a better understanding of this, segments from four triads, which are each very different, are presented.

For care triad C, there is clearly space for improvement. The resident misses home and believes the caregivers could gossip less and provide more gentle care. Her son experiences even more troubles with the caregivers and their communication. The caregiver does experience gratitude from the resident, however also experiences a challenging relationship with the resident's son.

> *"You can't do anything and here you sit in your chair and must stay seated. Every time you have to ask, can you do this for me? That is the worst."* Resident (negative)
> *"The caregivers often do not know [if mum attended the activities], because the volunteer arranges that. And that is…the communication is sometimes…if something happened you will not hear of it."* Son (negative)
> *"Family always wants to communicate with someone from management, while I really want to be there for their mum…I have actually never been part of all the conversations and I think that is a shame. I always ask why I am not invited and never get to hear anything about it [the conversations] or only later"* Nurse (negative)

For care triad F, the resident wanted more attention, recognized by each actor. This triad portrays a clear discrepancy in the resident's needs and expectations versus what the caregiver believes they can offer with their available resources; and a daughter who is quite positive.

> *"And if I need them [the nurses] for something, I call and then they come somewhere next week…they are busy."* Resident (negative)
> *"My contact with the caregivers is good. If they need me, they know where to find me. And if I need them, I will speak to them"* Daughter (positive)
> *"If you are busy with the medication round in the morning, she will already be standing in the hallway. And then she actually expects you to come directly to her. And when we tell her we will first do our rounds, because otherwise we may make mistake with the medicines, then she gets angry."* Nurse (negative)

Care triad O shows all actors touched upon the topic of dissatisfaction regarding the resident's participation in activities. On the one hand the resident wanted to be more active and on the other the resident did not want to participate when being offered the opportunity.

> *"Sometimes they take me to activities and sometimes they don't, because I fall asleep quickly…and it's a shame that they then don't wake me up [to join in]."* Resident (negative)
> *"And you know we also had to force him a little bit to participate in the activities that are here. Because he is also quickly the type to say, no never mind. And we did not want to have that because he soon will be lonely."* Niece (negative)
> *"He always says that he wants more activities and more physiotherapy, but when we ask him for things, he doesn't want to participate at all. But he always complains about this."* Nurse (negative)

To the contrary, in care triad V all three actors were very positive about the nursing home in general.

> *"Yes, I like to live here and I like to be here…it also gives me some security."* Resident (positive)
> *"Because she is happy with her life at the moment. She likes to be here. She has some aches and pains, but overall, I'm happy for her to be here right now."* Daughter (positive)
> *"From day one she felt like I feel at home and I don't want to go back."* Nurse (positive)

Valence scores for care triads (look)

To gain understanding of how to interpret the transcripts, each transcript was coded with positive and negative coded segments and these codes were transferred into a valence score. First, the total number of positive coded segments was calculated as a percentage of the total number of negative + positive coded segments for each transcript, resulting in a so-called %-positive per transcript. Second, to validate this scoring system, for 6 care triads these %-positives were compared to the interpretation if a transcript was considered positive or negative according to the researchers. This showed a minimum of 5 coded segments was deemed necessary to determine a legit %-positive that reflected the actual information

from the transcript. Third, the valence score was calculated to reflect the mean %-positive of the three actors in the care triad. This valence score was categorized as 0-25% (very negative), 26-50% (quite negative), 51-75% (quite positive) and 76-100% (very positive). The results are presented in Table 2.

Table 2. Valence and agreement score for each triad

Care triad	Resident %-pos	Family %-pos	Nursing staff %-pos	Mean %-positive score		Agreement score	
A	54%	69%	80%	71%	Quite positive	14	Very low
B	71%	87%	91%	83%	Very positive	81	Very high
C	20%	42%	56%	44%	Quite negative	11	Very low
D	76%	46%	56%	59%	Quite positive	40	Quite low
E	100%	75%	100%	90%	Very positive	75	Very high
F	0%	56%	25%	28%	Quite negative	25	Quite low
G	n/a	91%	88 %	n/a		n/a	
H	n/a	58%	90%	n/a		n/a	
I	100%	69%	53%	72%	Quite positive	9	Very low
J	46%	80%	75%	68%	Quite positive	45	Quite low
K	50%	100%	64%	72%	Quite positive	36	Quite low
L	50%	43%	69%	53%	Quite positive	68	Quite high
M	n/a	88%	69%	n/a		n/a	
N	90%	100%	81%	89%	Very positive	81	Very high
O	47%	40%	40%	42%	Quite negative	93	Very high
P	67%	41%	71%	53%	Quite positive	70	Quite high
Q	80%	56%	69%	67%	Quite positive	76	Very high
R	50%	33%	70%	57%	Quite positive	58	Quite high
S	41%	50%	67%	51%	Quite negative	75	Very high
T	30%	90%	75%	64%	Quite positive	35	Quite low
U	100%	100%	92%	97%	Very positive	92	Very high
V	100%	82%	100%	92%	Very positive	82	Very high
W	57%	46%	72%	61%	Quite positive	64	Quite high
X	38%	38%	65%	50%	Quite negative	24	Very low

n/a: less than 5 segments coded as positive/negative and therefore insufficient to calculate %-positive

Agreement scores for care triads (link)

To gain understanding of how the resident, family and nursing staff transcripts relate to each other, the %-positives were used as the basis for determining a level of agreement (agreement score) between the three actors. In a preliminary version, this score was calculated without making a distinction between the importance of the three actors. However, when presenting this intermittent version to the panel of experts, they determined that the resident's perspective should weigh heavier than the families', and that the lowest level of agreement is when the nursing staffs' views (the service providers) differ from the residents' (the service receivers). The reason for this is that nursing staff and residents have a continuous relationship in the nursing home founded on providing and receiving care, whereas family has a supportive role in this service encounter. This resulted in the calculation of an agreement score

based on the mean %-positive, with a hierarchy of combinations between actors as presented in Table 3. The starting point was that a difference of ≤25%-positive between actors was considered a high level of agreement, and a difference of >25%-positive between actors was considered as disagreement. The agreement level is selected based on the largest %-positive difference between two actors. This resulted in four categories: 1) resident & caregiver & family agree (very high agreement level), 2) caregiver & family disagree (quite high agreement level); 3) resident & family disagree (quite low agreement level); and 4) resident & caregiver disagree (very low agreement level). For all care triads, the agreement scores are presented in Table 2.

Table 3. Calculation and interpretation of agreement level and scores

Agreement level	Agreement outcome	Agreement score
Very high	Resident-family-staff agree (Δ %-pos ≤25%)	100 – (largest Δ %-pos)
Quite high	Caregiver and family disagree most (Δ %-pos >25%)	75 – (smallest Δ %-pos)
Quite low	Resident and family disagree most (Δ %-pos >25%)	50 – (smallest Δ %-pos)
Very low	Resident and caregiver disagree most (Δ %-pos >25%)	25 – (smallest Δ %-pos)

Combination of valence and agreement scores for care triads (learn)

The valence and agreement scores allowed for a visual representation in a graph. Figure 2 present the valence and agreement scores of 21 out of the 24 triads plotted into a graph. The x-axis presents the agreement level (from very low to very high) and the y-axis the valence (from very negative to very positive). Triads G, H, M had insufficient data from the resident to calculate a %-positive and have therefore not been plotted. The graph can be divided into 8 sections, which can help to interpret the placement of triads in the graph as presented in Figure 3. The positioning of a triad in the graph reflects the narrative data from the 'Connecting Conversations'. For example, the positive triad V is plotted in the right top of the graph, whereas the negative triad O is plotted in the right bottom. Figure 4 provides an example for the listen-look-link-learn steps for care triad 4.

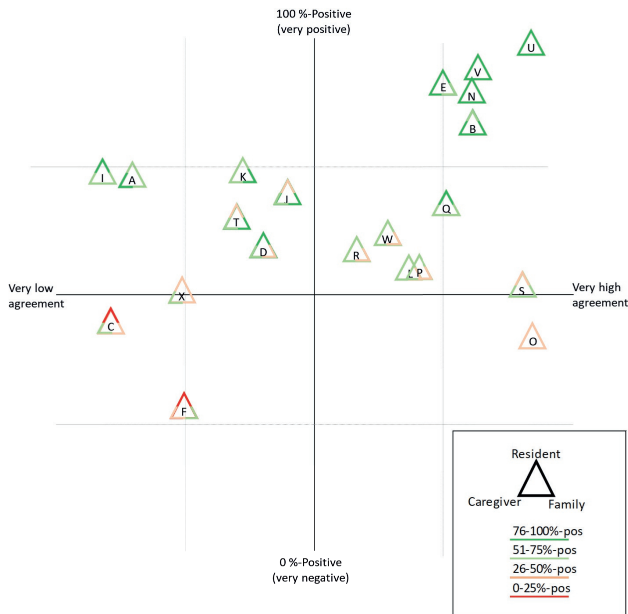

Figure 2. Quadrant-graph of agreement and valence scores for each triad

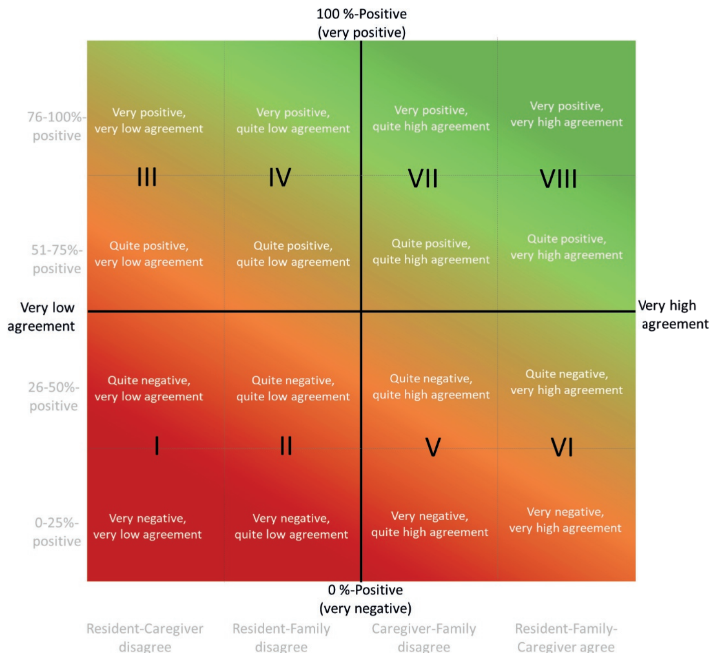

Figure 3. Interpretation of agreement and valence scores

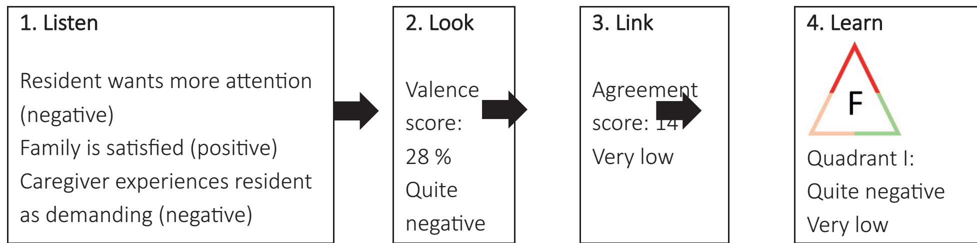

Figure 4. An example of how to use narrative 'Connecting Conversations' data (care triad F)

DISCUSSION

The aim of this study was to introduce an approach that enables the analysis of narrative data collected with 'Connecting Conversations' for quality improvements. Results indicate that narrative 'Connecting Conversations' data (listen) can be quantified into a valence score based on positive/negative segment coding (look), and an agreement score can be deducted from this (link). In addition, these scores can be positioned in a graph portraying the level of agreement between the resident, family and nursing staff (x-axis), and the mean %-positive of the triad (y-axis). The positioning in the graph can be interpreted into 8 categories ranging from very negative with very low agreement to very positive with very high agreement (learn).

Findings show that narrative data can be used to detect similarities and differences between residents, families and nursing staffs' experienced quality of care. Different actors contribute towards and benefit from creating added value to an experience.[27,28] Nursing homes strive to create a balance between the resident's, families', staffs' and organizations' needs (balanced centricity), which can also enhance their effectivity and performance.[29] Nursing staff have expressed their desire to collaborate more to find solutions and implement sustainable improvements, however, undertaking action together with families and residents does not occur automatically.[30,31] To improve this, a learning climate is needed in which a care organization aims at improvement by stimulating, facilitating and rewarding learning and development.[32] A successful learning climate positively influences organizational commitment and job satisfaction by providing space for decision-making, initiative and innovation, support and help from management, and support from and teamwork with colleagues.[33]

Our analysis show narrative data collected with 'Connecting Conversations' can be interpreted as a valence and agreement score. One might argue this defeats the purpose of using narrative data, as eventually only a quality rating is plotted in the graph whilst the story behind the rating is considered most meaningful. However, the graph of plotted triads should not be considered the final outcome, but a first impression of how a nursing home is performing. Based on this, a better understanding of the conversations can be achieved. Taking into consideration the desire for a more learning culture, it would be beneficial to provide care teams with the responsibility to reflect on and learn from narrative quality data together with residents and family. This provides care teams with more voice and responsibility in their quality reporting and improvement initiatives, which is a response to a recent Dutch advice pleading for a change in bureaucratic quality reporting.[34]

To support nursing staff to reflect on and learn from narrative quality data together with families and residents on an operational and tactical level, the 4-D cycle of appreciative inquiry can be used as a starting point as portrayed in Figure 5: discover and appreciate what is, dream and envision results,

design and co-construct, and sustain destiny.[35] To achieve this, it is recommended to assign a representative group with the responsibility of addressing the 4D's, consisting of nursing staff working on the participating ward, family, and residents living on the ward (hereafter called the quality team).[11] The members of the quality team are assigned as champions, which could increase the chance of successful quality improvements.[36] Together the quality team can identify what is going well and what could be improved on the ward based on the 'Connecting Conversations' data. They can do this by first discussing the findings in the graph (discover) and hereafter relating the positioning of the triads to the raw narratives elaborating on these scores (dream). In addition, they are responsible for providing the scores and narrative stories back to the care triads in order for the actors to discuss and align their differences and similarities (design). Especially for care triads with discrepancies between actors, it is recommended to have a meeting together aimed at discovering why there are discrepancies and what needs to be improved. Hereafter, learning objectives are formulated that can be applied in future care provision, focused both on what is going well and defining bite-sized improvement plans, keeping them achievable in the busy care routines (destiny).[37] On a strategic level, the quality team can report the valence-agreement graph with accompanied improvement plans back to management for transparency and accountability purposes. This operationalization of the 4D framework should be tested in practice.

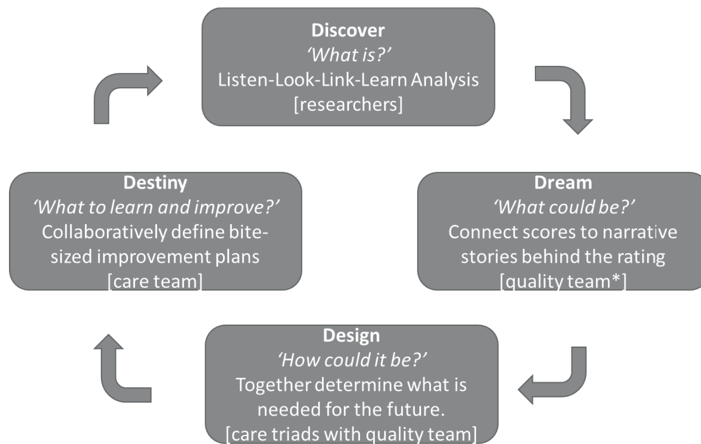

Figure 5. The 4-D cycle to learn from and use narrative quality data for quality improvements

For this study, several methodological considerations need to be addressed First, 'Connecting Conversations' is an assessment method adopting an appreciative inquiry (positive) approach. Questions asked are for example "what is the most positive experience in the nursing home?" and not the most negative experience. One might expect this enhances positive results. However, when adopting an appreciative inquiry approach, the negative is also addressed, yet respondents tend to dwell less in this and think more in sustainable opportunities.[38] Second, the cut-off for %-positive of 25% increments was manufactured. Henceforth, a resident with a 49% positive would be considered quite negative, whereas a resident with 51% positive would be considered quite positive. Therefore, it is important to no solely look at the %-positive, but also look at the relative difference in %-positive between the resident-family-

caregiver in the triad. Third, coding %-positive and plotting the graph is a time-consuming process prone to researcher's subjectivity. It is not expected that nursing staff performs the look-listen-link-learn analysis steps. Therefore, it is desirable to explore opportunities to automate this process with for example text-mining and sentiment analysis.[39,40] In addition, this would allow for more distinction between words used. As now, "it is great" and "it is quite good" are both coded with the same weight of positive, whereas sentiment analysis could correct for intensities of words and word combinations being used, providing a more actual representation of the narratives.

In conclusion, narrative stories collected with 'Connecting Conversations' contain useful information for care triads and teams to reflect on, learn from and improve with. It would be beneficial to embed 'Connecting Conversations' into a total quality management cycle of nursing homes and create a learning climate. Future research should however first focus on testing the use of valence and agreement scores in practice with the 4-D cycle.

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CHAPTER 5

Improving relationship-centered care during evaluation meetings with the resident-family-caregiver triad in nursing homes: a qualitative study

EMBARGO

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CHAPTER 6

Students' experiences with a hybrid learning environment in nursing homes: a qualitative study

6

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ABSTRACT

Introduction: Nursing homes are undergoing a culture shift from task-centered care to person- and relationship-centered care, requiring a different approach to how nursing home staff work and are educated. Hybrid learning environments aim to educate professionals who continuously work on their professional development by integrating and merging learning and working to facilitate the culture shift. The aim of this study is to explore how students experience learning in a hybrid learning environment in a nursing home setting and their perceptions of relationship-centered care.

Methods: A qualitative study design was used. The setting were nursing home wards organized according to a hybrid learning environment (n=2) located in the Netherlands. Participants were students (n=25; mean age=41) in two-year training for nurse assistants, three-year training for certified nurse assistants, or four-year training for vocationally trained registered nurses. Data were collected through semi-structured interviews and focus groups. Data were analyzed using direct content analysis.

Results: Findings show that students were generally satisfied with learning in the hybrid learning environment. However, the connection between working and learning was inconsistent, as students implied they did not see their everyday work as part of their learning process. Several improvement points for the role of work supervisor were made (e.g., greater dedication to update one's own professional knowledge and working according to recent nursing guidelines). Findings showed that students lack sufficient knowledge of the concept of relationship-centered care.

Conclusions: The hybrid learning environment in a nursing home setting remains underdeveloped. By considering some improvement points (e.g., clarity of the role of work supervisor and students' awareness of learning while executing daily tasks), the hybrid learning environment can promote a shift from working task-centered to working relationship-centered. Additionally, students must grasp the essence of the concept of relationship-centered care and need support in developing reflection skills to provide it.

Keywords: hybrid learning environment, relationship-centered care, continuing professional development, long-term care

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INTRODUCTION

Nursing homes, which provide 24-hour long-term care for older and frail adults, are undergoing a culture change from task-centered to person- and relationship-centered care. Person-centered and relationship-centered care are currently preferred approaches in long-term care and have become the standard for high quality of care in nursing curricula. Person- and relationship-centered care approaches aim to empower older people in shaping their own care process by considering their interests, paying attention to their requirements, and making an effort to empathetically fulfil their needs.[1] Furthermore, these approaches require a profound partnership between residents, family members, and nursing home staff within the care process. [2]

As a result of the culture shift, a different approach to work is required from nursing home staff. Skills such as compassion, basic knowledge, acceptance, and perseverance in applying person-centered principles were considered as crucial factors for implementing and improving person-centered care.[3,4] Competences associated with person-centered care are human understanding and communication, amongst others.[5] Ideally, nursing home staff gain those competences within their vocational training[6] and develop them further during their professional career. A recent review shows that nurses who receive continuing education, in the context of continuing professional development or in-service training, tend to provide more person-centered care.[7] Continuing professional development has been defined by the American Nurses Association as "a lifelong process of active participation by nurses in learning activities that assist in developing and maintaining their continuing competence, enhancing professional practice and supporting achievement of their career goals".[8]

Due to the cultural shift, the educational system plays an important role in preparing students for continuing professional development and required skills. In the Netherlands, the vocational education for nursing home staff such as nurse aid, nurse assistant, or vocationally trained registered nurse is mainly school-based combined with practical placements. Yet, scientific evidence supports the adoption of so-called hybrid learning environments to educate professionals.[9,10] Hybrid learning environments aim to educate professionals who are competent, continuously learn, self-direct their learning beyond formal education, self-reflect, and have a professional identity. [9,11-13] Within hybrid learning environments, learning and working are integrated and merged. Characteristics of a hybrid learning environment are that students simultaneously learn and work at a real workplace — i.e., the nursing home. These students are employed at a nursing home organisation and work in real-life situations (e.g., take care of residents). In the nursing home wards, students are supervised by experienced nursing home staff, who function as co-workers and experts on practical care tasks.[11] Theoretical knowledge is provided by teachers from a vocational institution, in a school-based setting at the same nursing home location to bridge the gap between theory and practice.[14] Students can tailor their curriculum by incorporating current issues occurring on the work floor into their theoretical sessions. This provides the opportunity for the students to link theoretical knowledge to real-life cases and the provided care. Furthermore, this can create opportunities for both students and experienced nursing home staff to reflect on the given care and facilitate the cultural shift towards providing relationship-centered care.

The concept of learning on the job is not novel. However, what sets the hybrid learning environment apart from previous systems is that students engage in both learning and work within the same organization, without transitioning between different internships. Additionally, unlike earlier on-the-job learning models, students are provided with the opportunity and are expected to take an active role in shaping their curriculum.

As students actively participate in the nursing home ward from the beginning of their training, they have a hybrid role: they are nursing home staff and students. Experienced nursing home staff also fulfil hybrid roles, as they are executing care tasks and educating students, which makes learning and developing a necessity. A study of Lillekroken et. al (2024) indicates that peer mentoring enables the transfer of knowledge and prompts students to establish links between their theoretical knowledge and its application in practice situations.[15] Furthermore, earlier studies in different settings have shown that

students appreciate the hybrid learning environment and perceive it as shared, meaningful, and reflective.[12,16,17]

However, there is limited knowledge regarding the experiences of students pursuing vocational education in a hybrid learning environment in a nursing home setting in the Netherlands. Furthermore, in the context of the cultural shift, the perceptions of these students of relationship-centered care have not been studied. Therefore, the aim of this study is to explore how students experience learning in a hybrid learning environment and their perceptions of relationship-centered care.

METHODS

Study design

A qualitative study design was used, consisting of semi-structured interviews and focus groups conducted between March 2021 and March 2023.

Participants and research context

Participants were students from a hybrid learning environment situated in two different nursing homes located in the Netherlands. In the Netherlands, nursing homes provide short-term rehabilitation care and long-term care for people with dementia or serve disabilities within psychogeriatric or somatic wards. Direct care teams in Dutch nursing homes mainly consist of nurse aids, nurse assistants, certified nurse assistants, and vocationally trained registered nurses.[18]

Participating students were pursuing a two-year training for nurse assistants, a three-year training for certified nurse assistants, or a four-year training for vocationally trained registered nurses, which led to a nationally recognised qualification. Students either enrolled straight out of high school or enrolled in a later phase of their life with prior experience in the nursing home or broader (healthcare) work field. Participating students consciously chose to enrol for the hybrid learning environment. Inclusion criteria were that the students were following an educational track that was provided in a hybrid learning environment. Participants were approached face-to-face by their teachers to participate in this study.

The training consisted of six hours of formal education per week provided at the nursing home location by teachers who were employed by a vocational institute. The underlying idea of giving theoretical lessons at the nursing home location was to merge theory and practice and therefore let the teachers participate in the practical environment. Furthermore, teachers received input from the students to shape the curriculum (e.g., addressing clinical pictures shown by residents of the ward).

Students were employed at the nursing homes. The contract time and the time they spent in practice varied per student between 16 and 32 hours per week. During every shift, there were more students than experienced nursing home staff present at the participating wards. As part of the training, students had to formulate individual learning objectives and select practical assignments which they executed during the working hours on the ward. They were supervised by the direct care team of the ward. Each student had one work supervisor, who had at least the educational level that the student was training for. The work supervisor was primarily responsible and the first contact for the student. This role consisted of providing feedback, offering consultation opportunities, and signing off on assignments of the student. Furthermore, the work supervisor had the role of a coach, which involved asking (in-depth) questions to encourage the student to think about different topics and approaches. The work supervisors encouraged the students to formulate learning goals from cases occurring in practice.

Data collection

Data were collected by means of semi-structured online interviews in 2021 and semi-structured face-to-face focus groups in 2023. A topic list based on the Clinical Learning Quality Evaluation Index (CLEQI) tool[19] was used, which evaluates the learning experience of students in their practical placement. Questions covered the following themes: demographic background, general experiences of the training,

(daily) supervision, implementation of theoretical concepts in practice, experiences with the learning process (e.g., impact of staffing and collaboration with other students on the learning process), and experienced degree of relationship-centered care in the ward (Appendix A). The semi-structured online interviews were conducted by the first and third authors (JR, PE). The interviews, which lasted 30 minutes on average, were audio recorded and transcribed verbatim. Notes were sent to the participants for a member check.[20]
As a follow-up measurement, focus groups were performed to get deeper insights. Focus groups have proven to be an efficient study design in situations where the goal is to gather information on complex relationships.[21] The focus groups were performed by three authors (KS, EH, PE) in 2023. The focus groups (n=3) lasted 80 minutes on average and took place at the nursing home locations with students from the hybrid learning environment. All sessions were audio recorded and transcribed verbatim. The topic list of the focus groups was tailored based on the interview findings (Appendix B). To start the discussion during the focus groups, a photo elicitation technique was used.[22] Participants were invited to select a photo that best reflected their experience of the training. With this technique, participants are triggered to reveal their true beliefs by combining images and words.[22] Thereafter, participants were asked about their expectations of their work supervisors and their teachers. Furthermore, questions were asked on how participants define and experience relationship-centered care in their ward.

Data analysis

Data were analysed with direct content analysis. Direct content analysis can be used to support or extend a theoretical framework or theory.[23] For this study, the CLEQI tool[19] was used as the theoretical framework to start the analysis and coding process. First, a deductive thematic coding approach was used. Predetermined codes were based on the topic list used (Appendix C). Afterwards, an inductive coding approach was used for emerging themes which were regarded as relevant but could not be coded with the predetermined codes. The coding process was conducted by two researchers (JR, EH). To draw conclusions from the coded data, all codes were grouped and categorised according to their content, similarities, and differences.[24] The data were analysed with MAXQDA version 22.7.0 software.[25]

Rigour

To enhance the rigour of this study, different strategies were applied. Initially, the first and second authors discussed the process of coding and analysis. Afterwards, investigator triangulation was applied by discussing the process with the whole research team, consisting of researchers with different backgrounds (i.e., psychology, nursing, education, and health sciences).[26] Triangulation of data was applied by using interviews and focus groups in the data collection to enhance the completeness of the findings. In qualitative research, triangulation is the process of using several techniques or data sources to create a thorough understanding of a phenomenon.[27] For this study, semi-structured interview and focus groups were used for data collection at different times and with different participants to apply triangulation of data. Through a member check, by sending the transcript to the participants after the data collection, participant verification was reached. The research team cross-checked the coding process and clustering of data, which led to a refinement of the coding frame.[28]

RESULTS

In total, 25 students from two different nursing homes participated (Tables 1 and 2).

Table 1: Participants' characteristics (n=25) †

Demographic characteristics	
Sex, n (%) female	23 (95,8%)
Age in years, mean (range)	41 (19-59)
Age group in years 19-29 n (%)	8 (33,3%)
Age group in years 30-39 n (%)	4 (16,7%)
Age group in years 40-49 n (%)	9 (37,5%)
Age group in years 50-59 n (%)	3 (12,5%)

Occupational characteristics	
Nurse assistant n (%)	3 (12,5%)
Certified nurse assistant n (%)	13 (54,2%)
Vocationally trained registered nurse n (%)	8 (33,3%)

† One participant did not provide (full) information on demographic or occupational characteristics

Table 2: Participants' distribution on measurements (n=25)

Measurement	Number
Interviews (2021)	N=10
Focusgroup 1 (2023)	N= 4
Focusgroup 2 (2023)	N= 4
Focusgroup 2 (2023)	N= 7

First, the experiences with the hybrid learning environment will be presented, followed by the perceptions of relationship-centered care.

Learning experiences

Analysis revealed three themes regarding how students experienced learning in the hybrid learning environment: 1) design of the learning process, 2) disconnection between working and learning, and 3) learning resources.

Design of the learning process

Within the interviews and the focus groups, the way that learning is organized in the hybrid learning environment and how students experienced learning itself were evaluated. All students reported that actively learning in practice made it more pleasant to learn compared with earlier learning experience they had. They appreciated the possibility to shape their own learning process by, for instance, adapting their learning goals to situations that occurred in the nursing home ward. Furthermore, students experienced a tailor-made learning process, in which they were able to complete tasks at their own speed, independent from their peers. According to the students, this promoted their motivation to learn. Whereas students appreciated this flexibility, first-year students especially were missing a certain degree of structure within their education. Due to the absence of sufficient structure, these students claimed

that they frequently lacked clear direction within their learning process. This made them uncertain whether they were learning correctly.

"*So that structure is important. And the structure of knowing* whether *I have it right and* whether *I don't have it right, you should also say it, and the structure of knowing where you stand. The structure of the day, but also the structure of where I am in my education."* (Participant, focus group 2023)

Furthermore, all students indicated that they felt safe to express their opinions, were able to ask questions, could learn from their mistakes, and received support in tough situations. They reported that they had the right amount of responsibility in their daily working activities, which fostered their learning process.

Disconnection between working and learning

The hybrid learning environment is designed to merge learning and working in the workplace. Yet, within the interviews, several students seemed not to make the connection between practice and theory by implying that they did not see their everyday work as part of their learning process.

"Do I have a learning objective today? No. Okay, then we can just work." (Participant, interviews 2021)

In addition, all interviewed students said that they used their learning goals to shape their learning process and appreciated that they were able to create their learning goals based on what they experienced in practice. Students used these learning goals as input for their theoretical lessons or to perform self-study. Vice versa, they also shared that they were able to apply theory from the lessons directly into practice. For example, students were taught the theory appropriate to a resident's clinical picture.

When asked about their experiences with their work supervisors and their teachers, the majority of students in the focus groups reported certain improvement points. They identified a lack of up-to-date theoretical knowledge of their work supervisors. They also expected their work supervisors to make a greater effort to expand their own knowledge. Simultaneously, students reported that they expect their teachers to have more insights about practical cases and specific clinical pictures occurring in the ward.

Learning resources

During the interviews and the focus groups, students reflected on several learning resources they have in the hybrid learning environment. Collaboration with colleagues and imitation of care staff performing care tasks (e.g., wound care or administering medication) are reported as important learning resources by the students. All students emphasized the importance of uniformity in how reserved nursing interventions are performed by work supervisors. Uniformity was crucial to reduce and prevent uncertainty for the students in the process of learning through imitation. The students reported that consistency in execution was crucial to ensure skill mastery.

"And I think not everyone has the same work attitude; not everyone is aligned on certain things. One does it this way, another does it that way, and someone else does it differently. So, I personally find it quite challenging to figure out whom to follow, who is right?" (Participant, focus group, 2023)

All students appreciated questions and feedback from their work supervisors, which motivated them to reflect on their learning and functioning. A personal click with the supervisor was considered an important prerequisite. They experienced a valuable learning process by discussing different approaches regarding specific practical cases. Furthermore, they reported that the learning process is very individual, and several students also learned from self-reflection and by coaching other students.

"Yes, because I work with first-year students who still need to learn everything; I also have to guide them. So, I'm not just a supervisor, but when I have to run an independent shift and I'm working with first-year students, I also need to teach them various things. This way, I can also assess my own abilities. I find it very enjoyable to teach people skills." (Participant, interviews 2021)

Relationship-centered care

Analyses revealed two themes regarding how learning in the hybrid learning environment influences students' perceptions of relationship-centered care: 1) recognizing the essence of relationship-centered care and 2) overstaffing and student–resident interaction.

Recognising the essence of relationship-centered care

During the interviews and the focus groups, students were asked to reflect on the relationship-centered care in their ward. When students were asked what relationship-centered care meant to them, they found it challenging to answer this question. They paraphrased definitions of person-centered care, such as "*the residents need to feel at home*" and "*we have to enhance their well-being and take into account their needs*", and mainly focused on activities which are offered to the residents. When asked about the extent of family participation, the majority of the students mentioned that family was informed about the care process of their relatives and that family occasionally participated in activities.
All students perceived themselves working more relationship-centered compared to other care staff, arguing that they are more used to asking questions and being curious. This resulted in them learning more about the residents and being able to better consider the residents' wishes and needs.

"And we also constantly assess: okay, this isn't working. But what is it that does work for that individual? So, we keep experimenting continuously. For example, [name] has a different idea than me, and then we continuously try to figure out: okay, what's the best way to motivate that person? I believe that we don't really look at the illness, but rather at the individual." (Participant, focus group 2023)

Furthermore, several students reported that due to the hybrid learning environment, they felt safe to try new things and considered different ways of working and were less stuck to (outdated) routines.

Overstaffing and the student–resident interaction

During the interviews, students reflected the number of staff on their ward and how this impacted their interactions with residents and other staff. A majority of the students reported that there was overstaffing on their ward due to the number of students. Consequently, students were not always able to actively participate in direct care tasks.

"Yes, everyone has to learn the same thing, so when something is exciting, everyone wants to be there, and that doesn't work. You can't have five people hovering over a resident and see what's happening. That's definitely a point of concern." (Participant, interviews 2021)

Most students also highlighted that, occasionally, they tended to sit together with other care staff instead of spending this time with the residents. In addition, several students felt that the ward was sometimes too crowded with direct care staff and students, causing agitation in the residents. On the other hand, all students reported that an advantage of overstaffing is that they had the possibility to spend more individual time with the residents, for instance, to go for a walk. Furthermore, they were able to take their time and have personal conversations with the residents during care tasks. This gave them the feeling of working more relationship-centered.

DISCUSSION

This study aimed to explore how students experience learning in a hybrid learning environment and their perceptions of relationship-centered care. Overall, the results of our study indicate that the hybrid learning environment offers potential to educate nursing home staff. Our findings show that, in general, students were satisfied with learning in the hybrid learning environment. They experienced the tailor-made learning process and actively learning in practice as motivating and pleasant. However, a certain lack of structure within the curriculum caused uncertainty among some of them. The connection between working and learning was not consistent, as students implied that they did not see their everyday work as part of their learning process. Regarding relationship-centered care, findings showed that students do not have sufficient knowledge of the concept. Nevertheless, they consider their way of working as highly relationship-centered.

Our study's findings demonstrate that students were motivated as a result of the way the hybrid learning environment is organised. Students within our study reported that they were motivated to learn, due to the degree of flexibility within their learning process. Motivation is essential for education and has been stated as "the heart of learning".[29] Our results are consistent with the Self-Determination Theory. The Self Determination Theory aims to explain how motivation arises [30]. To enhance motivation, three basic psychological needs have been identified: *the need for autonomy, the need for competence*, and *the need for relatedness*.[30] The *need for autonomy* and the *need for relatedness* can be translated to the results of our study.

First, supporting *students' autonomy* in the educational setting entails fostering their internal sources of motivation by honoring their opinions and suggestions.[31] Within our study, students reported that they experienced autonomy by having the opportunity to shape their own learning process (e.g., formulate their own learning goals based on real-life situations). Second, *relatedness support* can be provided by teachers and work supervisors. Being dependable, expressing delight in their interactions with students, displaying affection, being attuned, and allocating resources equally are factors that display relatedness support.[31] By merging theory and practice, the hybrid learning environment offers the opportunity for work supervisors and teachers to have close interactions with their students directly in practice. Students in our study reported that they appreciated the feedback given by work supervisors, but they missed a sense of being dedicated to update their own professional knowledge and working according to the most recent nursing guidelines. In addition, our results show that work supervisors did not always perform care tasks the same way. Supervisors who function as role models have an essential impact on the quality of the educated nurse [32]. Modelling, or the imitation of another person's behavior, has been recognized as a strong learning mechanism in the nursing profession.[32,33] Therefore, it is recommended that work supervisors in the hybrid learning environment set an example in being engaged in the learning process of their students. They are expected to show curiosity and have profound theoretical knowledge. Future research should investigate the view of the work supervisors on their role and potential facilitators and barriers in educating nursing home staff within a hybrid learning environment.

In this study, students implied that they do not see their daily work as part of their learning process. This result might be contradictory to the goal of the hybrid learning environment to educate nursing home staff that continuously work on their professional development. In concepts such as continuous professional development and life-long learning, the most essential characteristics are reflection, engaging in learning by actively seeking learning opportunities, questioning, enjoying learning, and understanding the dynamic nature of knowledge.[34,35] Therefore, it seems crucial that students are aware of the process of learning while executing daily care tasks. The literature suggests that nursing home staff particularly engage in work-based learning and executing daily tasks (e.g., taking care of residents).[36,37] Nursing home staff learn individually and collectively while working with residents in everyday situations.[36]

The results of our study show that students' perspectives on relationship-centered care are mostly practical, with an emphasis on organizing and carrying out activities. Yet, relationship-centered care encompasses more than practical application such as activities for residents. The concept of relationship-centered care stresses the importance of interactions and relationships between residents, family members, and nursing home staff.[38] The relationship between nursing home staff and residents is a core element of the care process.[39] The literature suggests that all activities of daily living offer opportunities to build and work on the relationship.[40,41] These results demonstrate that there is a discrepancy between the prevalent care philosophy and the real care given, as seen by divergent care values, processes, and priorities in care practices. In addition, the students' interpretation of the concept indicate that they have low foundational knowledge, which might indicate that they are expected to offer care beyond their competences. When nursing home staff receive continuous education and practical supervision and adhere to the same care philosophy, the literature demonstrates that person-centeredness is higher.[42,43] Therefore, it seems important that work supervisors and teachers provide students a deeper understanding of the concept as part of their training.
At the same time, students indicated that they rate their behavior and actions as highly relationship-centered. However, they had trouble underpinning this with examples. Earlier research indicates that nursing home staff overestimate their own competencies and ways of working.[44,45] In doing so, they may not always accurately assess their own behavior and reflect accurately on their actions. Reflection on behavior and actions might be particularly important to provide relationship-centered care as relationships are not uniform. Moreover, residents, family members, and formal caregivers have different perspectives and needs.[46,47] A tension between different perspectives asks for skills such as understanding human behavior (empathy), professional communication, and critical reflection.[5,35,48] In addition, reflecting on the provided care might be beneficial for nursing home staff and students in order to identify the important components of relationship-centered care.[49] A review by Edgar et al. (2023) found that practical supervision can help nursing home staff to become more self-aware and reflect on their decisions in practice.[50] In the light of our findings, an important implication for the work supervisor is to support students in developing self-reflection skills. Due to the different perspectives, it seems necessary for future research to investigate how residents and family members experience living in a hybrid learning environment.

For this study, several methodological considerations need to be addressed. The fact that this study included only two teams from two distinct nursing homes in the Netherlands may have impaired the data's representativeness. It is challenging to determine whether the sample size contributed to data saturation. In order to capture diverse parts of the findings and improve completeness, triangulation of data was performed by conducting interviews at different periods of time and focus groups. A member check was conducted to ensure data accuracy.

CONCLUSION

The hybrid learning environment in a nursing home setting remains underdeveloped. It offers an opportunity to educate nursing home staff that can promote a shift from working task-centered to working relationship-centered, but the role and the tasks of the work supervisor need to be clearly described and acted out. It seems crucial that students are aware of the process of learning while executing daily care tasks. Additionally, students need to grasp the essence of the concept of relationship-centered care and need support in developing reflection skills to provide relationship-centered care. This could help the transition from working task-centered to working relationship-centered.

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CHAPTER 7

General Discussion

7

The aim of this dissertation was to investigate how relationship-centered care can be enhanced in nursing homes. It addressed two main research questions:

1. Which work environment factors contribute to relationship-centered working in nursing homes?
2. How can nursing home staff be facilitated to improve relationship-centered care?

To answer these questions, various aspects of the work environment (chapters 2 and 3), usability of narrative data on experienced quality of care (chapters 4 and 5) and educational experiences of students (chapter 6) were investigated. In this chapter, the main findings of the studies conducted are presented, methodological and theoretical considerations are discussed and recommendations for future directions in nursing home practice, education and research are made.

MAIN FINDINGS

First, the analysis of a large data set revealed factors of the work environment that contribute to relationship-centered care. These factors included unity in the philosophy of care, teamwork and job characteristics such as work satisfaction, task variation and development opportunities of nursing home staff. Another important work environment factor was nursing home staff leadership. In particular, characteristics attributed to a transformational leader were associated with better person- and relationship-centered care (chapter 2). Leaders who provide active social support, facilitate non-hierarchical teamwork and have a clear care philosophy on care provision seemed to have a positive association with relationship-centered care. In addition, leadership became even more relevant during extraordinary situations, such as the COVID-19 pandemic (chapter 3). During the pandemic, nursing home staff experienced a conflict between their role as healthcare professionals and their personal lives. They anticipated the leader's physical presence, decisive actions, understanding of the challenges faced while working during the pandemic and recognition of their efforts.
Furthermore, nursing home staff did their best to provide relationship-centered care, which occasionally conflicted with the rules and regulations of infection prevention. Nevertheless, teamwork notably improved during this time (chapter 3).

Second, this dissertation explored whether narrative data can be used to detect similarities and differences between residents, families and nursing staff members' experienced quality of care (chapters 4 and 5). Narrative data provided valuable information about relationship-centered care and can thus serve as a basis for dialogues within the care triad of resident, family member and nursing home staff (chapter 4). However, in practice, professional collaboration with residents, family members and nursing home staff did not occur automatically (chapter 5). Primarily nursing home staff were invited to meetings at which quality of care was discussed.
Engaging family members and residents in quality improvement processes remained challenging. Moreover, the focus was on incidental problem solving, and the full range of details provided by the data was not utilized to reflect on relationship-centered care (chapter 5).
The development of a hybrid learning environment, as discussed in chapter 6, seems promising to foster a transition from task-centered to relationship-centered approaches in the education of future nurses and nurse assistants. Students were satisfied with learning in the hybrid learning environment and experienced the tailor-made learning process. However, they did not have sufficient knowledge of the concept of relationship-centered care. Other areas for improvement were clarifying the role of work supervisors and enhancing students' awareness of learning during daily tasks (chapter 6).

METHODOLOGICAL CONSIDERATIONS

In this paragraph, an overview of the general limitations and strengths of the methodologies used is presented.

Participants and setting

Despite the emphasis of relationship-centered care on addressing the needs and perspectives of residents, family members and nursing home staff alike,[1] the data collection in this dissertation primarily involved nursing home staff. The reason for this is that the studies conducted aimed to facilitate improvement from the perspective of the nursing home staff. Hence, we cannot determine what the additional results would have been if we had included residents and family.

Incorporating residents and family members into data collection and interpretation at all stages of a study is a preliminary step toward enhancing relationship-centered care,[2] with the primary focus remaining on the residents.[3,4] Involving residents and family members at all stages of a study often yields surprising perspectives, choices and priorities as well as interesting results.[5] However, this has not been adequately addressed within the scope of this dissertation and should be considered as a limitation.

To explore the perspectives of residents and family members comprehensively, several aspects need consideration. Ensuring their privacy, involving staff in the planning and execution of the data collection and positive and reciprocal relationships have been highlighted as facilitators of the involvement of nursing home residents in research.[6,7] Earlier research has also found that residents and family members are generally positive about participating in research.[6] Especially when the relationships between residents and nursing home staff, as well as staff and family members, are strong, collaboration appears to be more beneficial for research purposes. Therefore, supporting residents and family members, training staff how to provide support and facilitating good relationships with residents and family members might enhance the participation of residents and family members. To increase participation, various other methods could be considered, such as observations, photovoice,[8] photo elicitation[9] or resident diaries.[5]

The focus of this dissertation was on measuring (factors related to) relationship-centered care on the micro level (nursing home staff). The meso level (i.e. management, workplace culture and physical environment) was only partially considered in the studies conducted. Earlier research has suggested that factors like involving staff at the meso level, such as in planning and development, or providing staff with structural empowerment can exert a positive impact on relationship-centered care.[10-12] These aspects could have enhanced our results. Factors associated with the macro level (organization and broader societal influence) were not considered in the studies conducted. These factors, such as physical support (i.e. financial resources and changes to the environment),[13] could be potential facilitators of and barriers to the implementation of relationship-centered care and should therefore be taken into account in the future.[14]

Rigor

For this dissertation, the majority of studies used qualitative methods. Qualitative data can be used to gain a rich understanding of complex phenomena and aim to provide in-depth insights into and understanding of real-world problems.[15] Therefore, ensuring the trustworthiness of the data is crucial. In qualitative research, the term “trustworthiness” can be considered as an equivalent for the terms “validity” and “reliability” in quantitative research.[16,17] Criteria to ensure trustworthiness are, among others, *credibility* and *reflexivity*.[17]

Credibility determines whether the research findings accurately reflect plausible information derived from the participants’ primary data and offer a correct interpretation of their original perspectives.[16] We used different types of triangulation for our qualitative studies to enhance their credibility.[17,18] Data triangulation was applied by collecting data at different moments in time.[19] This is applicable to the study

presented in chapter 6, in which students shared their experience with a hybrid learning environment during their first year and two years later. As a result, a distinction could be made between experiences related to the initial challenges of the hybrid learning environment and general issues with the method of education. This could have been enhanced further with additional follow-up measurements to track potential improvements and adjustments in the curriculum.
Methodological triangulation was employed, initially by conducting interviews and then by establishing focus groups to gather more in-depth information (chapters 5 and 6).[19] As mentioned earlier, nursing home staff members constituted the main study population of this dissertation, but, to include residents, field observations could have been conducted, which might have deepened or even altered the results. This approach might have provided an even better insight, for instance into the lives of the residents, especially those who are no longer able to participate in interviews or focus groups verbally.
For all the qualitative studies, at least two researchers were involved in the data analysis, supporting the concept of investigator triangulation.[19] During the coding process, differences were discussed and ultimately resolved through consensus in the research team.

Reflexivity refers to the extent to which researchers aim to convey the information provided by the participants faithfully, thereby ensuring that the data interpretations are as concise as possible and not influenced by preconceived ideas.[20] The research team consisted of researchers who all have a background in nursing home care with additional experience of different disciplines (i.e. psychology, education and the nursing profession, and health sciences). The respective backgrounds of the researchers might influence various stages within the research process.[17,20] The method of data collection, the setting and the selection of participants can be particularly influenced by the background of the researcher, especially within the context of qualitative research.[20] Furthermore, researchers' background and experiences affect their interpretation of the results.[17] To enhance reflexivity, regular team meetings took place. During these meetings, the researchers identified variations in interpretations during discussions and reflected on their research background, previous work in clinical practice and personal preconceptions regarding the quality of care. Furthermore, the fact that the professional background of the researchers varied might have minimized any bias. Nevertheless, we could have discussed the analyses and the results with other parties, such as nursing home staff, residents and family members, to gain different or new insights or potentially to reinforce our statements.

Person- or relationship-centered care?

For this dissertation, both person-centered care and relationship-centered care were used as outcomes. However, one might wonder what the difference is? A closer examination of the two concepts is necessary to reflect on the findings of this dissertation.

The two concepts, person-centered and relationship-centered care, have already been studied over the last three decades. In 1997, Kitwood formulated the theory of person-centered care for persons with dementia, emphasizing the importance of addressing their psychosocial needs and recognizing the individuality of each person.[21] McCormack, in 2003, presented the first conceptual framework for person-centered practice with older people.[22] Several definitions and frameworks for tailoring the care process around the individual person followed.[23-27] Person-centered care is commonly recognized today as an equivalent to "best practice" and "evidence-based practice" in nursing home care.[28,29] However, researchers have raised concerns regarding the lack of consensus surrounding the precise definition of person-centered care.[26,30-32] The operative definition, in contrast to the more recent theoretical definitions of person-centered care, is often primarily concerned with promoting individualism and autonomy.[33] This perception of person-centered care may underestimate the complexity of the concept by overlooking the importance of interdependence, relationships, shared decision making and fostering connections within broader social networks.[1,33-36] These considerations prompted the development of the concept of relationship-centered care. Relationship-centered care encompasses a variety of needs, desires and perspectives of all persons included in the care process.[37,38] Furthermore, it recognizes the

individual as a participant in their interactions and acknowledges the relationships that emerge during the care process.[39] Hence, one could argue that relationship-centered care represents an expansion of the person-centered care concept.

Currently, there is no standardized instrument to measure person- and relationship-centered care in nursing homes. For the study presented in chapter 2, we used the LAD study data, which included the Dutch version of the Person-Centered Care Questionnaire (PCC)[40] to measure staff-reported person-centered care. A potential weakness is that the measurement of staff-reported person-centered care relied on individuals' perceptions of their own performance, thus introducing subjectivity into the assessment. Moreover, there has been a suggestion that care staff may exhibit bias in providing socially or politically correct responses regarding person-centered care.[41]

To take into account all the perspectives involved, we decided to use the narrative Connecting Conversations method to measure relationship-centered care in chapters 4 and 5. A strength of this method is that it takes into account all three perspectives of residents, family members and nursing home staff. Furthermore, the method has been shown to assess completely the construct of experienced quality of care and therefore meets the requirements for face, content and construct validity, which contributed to the quality of our studies.[42] Nevertheless, Connecting Conversations is a narrative measurement that has weaknesses, for instance that residents with dementia who were not able to participate verbally in interviews were not included in the study. Additionally, the analysis of narratives provided by residents with moderate to severe cognitive impairment needs to be approached with caution. Studies have indicated that this process may be less reliable due to residents' potential challenges in comprehending questions accurately and recalling past experiences.[43] In the past years, several innovative qualitative methods have been described to involve people with dementia in research, such as ethnographic observation, photo elicitation and visual and sensory adaptations to interviews.[44] To involve all residents in the data collection process, these methods should be considered.

THEORETICAL CONSIDERATIONS

Implementation of relationship-centered care in a practical setting

The implementation of person- and relationship-centered care in practice remains challenging due to the multitude of factors influencing its successful execution. This underscores the need for special attention to be directed toward relationships and interactions within the care process. Enhancing collaboration in the care triad is necessary. Furthermore, the underlying values of all the involved parties emerge as crucial for the concept of relationship-centered care. These interactions and relationships appear to have been insufficiently addressed within the widely used frameworks of person-centered care, including the framework for person-centered nursing.[25] In the updated version of the person-centered nursing framework, McCormack and McCance described four dimensions that influence person-centered practice: prerequisites, the care environment, the person-centered process and person-centered outcomes.[45] It can be assumed that there is a dependency relationship between these dimensions, namely insofar as the prerequisites must be fulfilled first and then the care environment must be conducive to achieving a person-centered process and outcome.[45,46]

The first dimension, the prerequisites, involves staff attributes, such as being professionally competent, having developed interpersonal skills, being committed to the job, being able to demonstrate clarity of beliefs and values, and knowing oneself.[45] Our findings underpin these attributes and add three job characteristics that are associated with person-centered care: social support from the leader, work satisfaction and task variation, and development opportunities. These show that not only the attributes

of the staff but also the nature of the job play an important role for nursing home staff when they want to deliver person-centered care.

McCormack and McCance further argued that, even when the prerequisites are in place, if the care environment fails to facilitate person-centered approaches to work, nursing home staff will be unable to realize their maximum potential.[45,47] This leads to the second dimension: the care environment. The care environment entails factor such as an appropriate skills mix, systems that facilitate shared decision making, the sharing of power, effective staff relationships, organizational systems that are supportive, potential for innovation and risk taking, and the physical environment.[45,48,49] It is increasingly acknowledged that the context is a multifaceted phenomenon. While it may be straightforward to define what it encompasses (for instance the care environment), specifying its characteristics and qualities is more challenging.[50-52] Our findings indicate that work environment characteristics (i.e. transformational leadership and unity in the philosophy of care and teamwork) are associated with person-centered care and contribute knowledge to gain a more comprehensive view on the care environment. Within a nursing home, relationships and collaboration play important roles. To achieve unity in the philosophy of care and shared values, collaboration among leaders, care staff, clients and family members is crucial to enhance person-centered care.
The third dimension described within the person-centered nursing framework consists of the person-centered processes, which concentrate on the care delivery and include working with persons' beliefs and values, engagement, having a sympathetic presence, sharing decision making and meeting physical needs.[45] Nursing home staff primarily aspire to offer person-centered care and perceive it as a crucial aspect of their job but encounter difficulties in implementing it in practice.[47,53] Furthermore, they grasp the concept of person-centeredness at a fundamental level, but they lack clarity on how to incorporate their task-oriented routines into the provision of person-centered care, as confirmed in this disseration.[47,54] In our study, nursing home staff tended to discuss themes related to relationship-centered care superficially, acknowledging, for instance, the need for communication but failing to delve into its importance or its impact on the care process while primarily resorting to problem-solving approaches. This shows that, among other things, solid collaboration and communication within the team are important to reflect genuinely on, for example, person-centered processes and that these do not happen automatically.
Lastly, the fourth dimension of the framework includes the expected outcomes of effective person-centered nursing: satisfaction with care, involvement in care, a feeling of well-being and creating a therapeutic culture.[45] In the context of this dissertation, these elements were considered to be outcomes of experienced quality of care, as also described in the "INDEXQUAL framework".[55] This framework presents experienced quality of care as an interactive process that can be assessed by means of perceived care services (what happened and how did it happen?), perceived care outcomes (how did it influence the health status?) and satisfaction (how did it make someone feel?). This shows its relatedness to the concept of experienced quality of care.

One may conclude that, while there is considerable theoretical knowledge about relationship-centered care, the implementation remains challenging. The questions of why that is the case and what constitutes the theory–practice gap remain. A theoretical model aims to describe how reality appears. A theory should ideally also explain and predict what occurs in practice and in the future.[56] Given the challenges associated with implementing person- and relationship-centered care, one might question the extent to which the existing frameworks display an adequate model of the concept of person- and relationship-centered care. Indeed, the degree to which the conceptualizations of person- and relationship-centered care hold true could be considered as research regarding its actual effectiveness in care for older people in nursing homes is lacking.
At present, we are still in a phase of different hypotheses about relationship-centered care. This could be a reason for the implementation failures. Implementing relationship-centered care in practice is a continuous process that involves different stakeholders and demands enduring dedication from organizations to foster advancements. Organizations encourage progress by involving teams from

different levels within the organization. Contextual elements, such as the workplace culture, learning culture and physical environment, present the most significant hurdle to relationship-centered care and the cultivation of cultures capable of upholding relationship-centered care over time.[57-61] As long as these elements do not fully engage in the cultural shift, the implementation of relationship-centered care remains superficial and inadequate. It appears to be challenging for organizations to shift from "relationship-centered moments" to establishing "relationship-centered cultures" in which they need to depend not solely on the individual motivation of practitioners but rather on a culture of collaborative teams that foster person-centeredness.[62]

Additionally, just as individuals vary, putting relationship-centeredness into practice varies across settings and cultures. Culture appears to influence whether and how person-centered care is practiced.[63,64] Considering that culture provides the language and settings in which individuals negotiate shared values and perspectives, paying attention to culture is crucial when implementing person-centered care.[65] While it is feasible to identify common denominators, their implementation in practice must adapt in diverse ways depending on the context, rendering the execution complex.
It must also be considered that relationship-centered care does not hold the same meaning for every resident, family member or staff member, for instance. One individual may prefer autonomy, being asked daily how they take their coffee, while another may appreciate the nursing staff already knowing their preferences. It has often been suggested that nurses adhere to routines and therefore do not work in a relationship-centered manner,[66] although, in some cases, this may indeed be the case.
Relationship-centered nursing assumes a behavioral change among staff who have been working in a certain way for many years, with training that may be outdated, which is not a simple or quick process. It requires changing the routines in which the behavior is embedded to alter the behavior in the future.[67] Thus, it appears to involve not only acquiring specific skills but also fostering a culture shift among both established nursing home staff and those in training. A different type of education, for instance a hybrid learning environment of nursing home staff, offers an opportunity to educate nursing home staff that can promote a shift from task-centered working to relationship-centered working. A recent review has suggested that nurses who participate in continuing education, whether through continuing professional development or through in-service training, are more likely to offer person-centered care.[68] This could be a first step in supporting nursing home staff in the behavioral change.

Collaboration within the care triad

Relationship-centered care entails recognizing the significance of the needs and desires of all the stakeholders involved.[39] Professional collaboration with residents, family members and nursing home staff does not happen spontaneously, as found in our results. In particular, collaboration with family members and residents in quality improvement processes poses a challenge. Ideally, in the nursing home setting, the needs and desires of residents, families and nursing home staff are considered as equal. However, in practice, this equilibrium is often not achieved. Our findings underpin this situation as family members were by deliberately not invited to evaluation meetings to "avoid uncomfortable discussion." Nursing home staff often encounter challenges when collaborating with family members, perceiving them to be "difficult" or "demanding."[69,70] Furthermore, organizational circumstances, such as perceived workload, financial constraints and time constraints, frequently lead to an emphasis on task- rather than relationship-centered care and therefore hamper the collaboration.[57]

To attain a balance between the values and needs of residents, families and staff, the concept of Balanced Centricity can be employed.[71,72] Earlier research has indicated that adopting the Balanced Centricity approach in a nursing home setting may enhance the well-being of all stakeholders.[71] This refers to a scenario in which the interests of all the involved stakeholders are met equally.[73] Originating from service sciences, this emphasizes that, beyond the customer (i.e. resident), a diverse network of stakeholders exists. Balanced Centricity underscores the importance of recognizing the values of multiple stakeholders as each contributes to the collective value creation process. It posits that the actions of one stakeholder benefits others within the network. Therefore, Balanced Centricity claims

that all stakeholders' roles are essential for collaborative value co-creation. Emphasizing the inclusion of a variety of stakeholders, it suggests that this approach is crucial for balancing needs and fostering consensus.[74] However, in the case that stakeholders have conflicting interests, the well-being of one stakeholder may adversely affect the well-being of another, ultimately compromising the overall well-being of the network.[75] Balanced Centricity in the context of the nursing home setting could be seen as a prerequisite for relationship-centered care. When the needs and interests of residents, family members and nursing home staff are balanced, relationship-centered care may be enhanced.[71]

Nursing home organizations can promote a supportive approach to Balanced Centricity by, for instance, engaging residents, family members and nursing home staff in dialogues about the experienced quality of care and integrating these dialogues into daily routines.[76] The findings of our study indicate that these dialogues do not occur spontaneously, especially as collaboration with family members and residents remains challenging.

To facilitate positive relationships between family members and nursing home staff, engaging in informal communication and establishing personal connections appear to have positive effects.[77] Transparent and sincere communication, attentiveness and mutual respect for each other's perspectives and contributions seem to be crucial components for the cultivation of partnerships among individuals.[78,79] Moreover, establishing good collaboration is likely to be an ongoing and challenging process, involving obstacles such as declines in resident (mental) health or staff turnover.[77] Open conversations about arising dilemmas and differences in perspectives can contribute to a closer collaboration. Reflecting upon and deliberating over arising obstacles and differences may result in initiatives to enhance relationship-centered care.[80]

Although we know how important and promising relationship-centered care in the nursing home setting is, the COVID-19 pandemic has shown us that the concept is not yet firmly established. Despite the extensive knowledge of person- and relationship-centered care, the COVID-19 pandemic was a stark reminder that, when extraordinary events occur, all principles are set aside, with safety taking precedence above all else.[81,82] To ensure safety, nursing homes were sealed off from the outside world. The pandemic forcefully shifted the attention of policymakers and management to prioritizing safety above involving residents and their families in decision making and tailoring care to their needs. Preventing residents from contracting the virus became the highest priority, which was an understandable measure in the situation at that time. However, our findings demonstrate that, even during this time, the concept of relationship-centered care was crucial for all involved. Nursing staff consistently faced the dilemma of balancing adherence to regulations with their desire to deliver relationship-centered care.[83] Residents were no longer allowed to receive visitors and went for long periods without seeing their loved ones. It was also distressing for family members to be prohibited from visiting their loved ones in the nursing home.[84] Nursing staff encountered a heavy workload while witnessing residents' distress.[84,85]

Even though the detrimental impact of the measures on all the involved parties has been acknowledged, it is now evident—after the pandemic—that some measures are being maintained, regardless of their negative influence on relationship-centered care. For instance, some nursing homes that introduced visiting hours and restrictions on family visits during the pandemic have maintained these measures (e.g. family members not being allowed to enter common areas and residents only receiving visitors in their own rooms).[86] This situation was justified by the argument that it would reduce perceived "agitation" among residents, albeit without any scientific basis.[87] These unjustified measures are in complete opposition to the concept of relationship-centered care. Overall, the COVID-19 pandemic and the time thereafter demonstrate that the concept has not yet been fully integrated into practice. It highlights the considerable potential for advancement in the future.

FUTURE DIRECTIONS

The findings presented in this dissertation have several implications for future practice and research on enhancing relationship-centered care in the nursing home setting.

Practice and education

First, establishing a learning environment is recommended as translating the concept of relationship-centered care into practice involves multiple facets and layers. Within this learning environment, care organizations aim at improvement by stimulating, facilitating and rewarding learning and development.[88] Nursing home staff need to have the ability to reflect on their own actions and the quality of care that they provide, preferably together with family and residents. Therefore, a learning environment is essential for a care organization, which is characterized by the encouragement, facilitation and recognition of learning and developmental efforts of staff.[88] Within a learning environment, nursing home staff, family and residents can use narrative data to reflect, learn and improve.[89] Furthermore, nursing home staff can develop their knowledge and skills through, for instance, mutual observation or by having regular team meetings to exchange, debate and discuss different approaches to enhance relationship-centered care.

Second, to improve relationship-centered care, good family–nursing home staff relationships are essential to support the residents in the best possible way.[69,90,91] Hence, continuous dialogues to discuss the expectations and preferences of both parties are needed. Communities in which family members truly feel included and nursing home staff no longer perceive family members as burdensome are needed.[91] Accordingly, organizations need to establish a clear vision regarding partnering with family members and to allocate resources to facilitate such partnership collaboration. A tailored approach is key, for example through group meetings or individual collaboration. Nursing home staff could, for example, be allocated time to schedule conversations with family members and residents to discuss the experienced quality of care. Alternatively, organizations could regularly hold family events tailored to the preferences of the family members. Practical considerations, especially regarding which time suits family members best, whether they require special transportation and which location is most suitable for a meeting, should be considered. These events frequently occur in practice yet do not consistently produce positive outcomes. One contributing factor may be the lack of active involvement of family members in the planning process and agenda setting, leading organizations to make assumptions about their preferences. Hence, it is important to partner with family members, viewing them as equals and attributing them an active role with a voice in these matters.

To engage in these conversations, nursing home staff need to feel equipped with the necessary competencies, for instance using appreciative inquiry conversations. It has been acknowledged that learning is acquired best through practical work activities.[92-95] This method of informal learning takes place on the individual and collective levels and can be facilitated by, for instance, organizational support.[95] Specifically, this means that organizations, for example, could support these conversations by implementing role models, who show nursing home staff in practice how to engage in these conversations. Additionally, they could give staff the opportunity to practice these conversations on one hand and observe colleagues conducting these conversations on the other hand to provide mutual feedback.

In the long-term care setting, it is also necessary to consider that there are family members who do not desire active collaboration with staff and prefer to take a passive role. Additionally, it must be noted that there are many residents who, for instance due to verbal limitations, are no longer able to participate actively in collaboration. For these cases, organizations should contemplate alternatives that still allow for the practice of relationship-centered care. Therefore, alternatives, such as indirect participation through a designated resident and family representative, may be explored to achieve the best collaboration possible.

Third, consideration needs to be given to the education of nursing home staff regarding the necessary skills to provide relationship-centered care. To educate future nursing home staff who are constantly

learning and who have the skills to provide relationship-centered care, these skills need to be imbedded in the curriculum. It seems important for students to grasp the concept of relationship-centered care during their education to close the theory–practice gap. Another problem of the theory–practice gap is that new students often join an established team and are expected to adhere to the status quo of "this is how we've always done it," regardless of the knowledge that they may have gained from their education. In this regard, students need to stand firm and resist being swept along by the prevailing practices. Conversely, established teams must be receptive to new perspectives and insights.
To reflect on their own actions, students could learn desirable skills as part of their practical training and in their interactions with colleagues, residents and families. Additionally, an important role in this regard can be attributed to the practical supervisor of the students. The personal supervisor could practice these skills with the students during their practical training on practical cases. The supervisor needs to have a good grasp of the concept of relationship-centered care and be able to guide the students in acquiring new skills. Experienced nursing home staff can fill the role of supervisor and can improve their own skills in their interaction with students.

Research

First, it seems necessary to gain more insights into the theoretical meaning and interpretation of the concept and the effects of relationship-centered care on the residents. The results of this dissertation have indicated various factors that contribute to relationship-centered care. However, as the results primarily focus on the perspective of the nursing home staff, further research is needed on how residents and family members experience relationship-centered care. This should be measured on the residents' level to include their experience of relationship-centered practice.[3,5] Furthermore, it seems important to investigate how residents, family members and nursing home staff can become more equal partners to create balanced centricity.

Second, additional research is needed to explore how nursing home staff, in partnership with residents and family members, can continuously evaluate the experienced quality of care and implement improvement strategies to deliver and receive a high quality of care. Employing an action research approach could aid in providing a more comprehensive description and understanding of the underlying processes.[96,97] Various strategies to enhance collaboration, such as implementing regular dialogues and training staff in appreciative conversations, need to be tested and evaluated in practice. This is a suitable design as strategies can be adjusted and evaluated by participants in real-life settings. It is also important to explore more thoroughly how family members can actively participate in the evaluation process.

Third, it is important to research how relationship-centered care can be implemented on the macro, meso and micro levels simultaneously. By covering all three layers within one piece of research, it would be possible to explore the dynamics existing between the different layers. The framework by McCormack[45] assumes that there is a relationship between the different layers and that these layers influence the implementation process. Therefore, it is important to examine this interaction more closely. Additionally, a comprehensive approach, developed in co-creation with representatives from all three layers, should be developed to enhance the implementation of the concept.

Finally, further investigation is needed into how nursing home staff can learn most efficiently to provide relationship-centered care in practice in collaboration with residents and family members. It is especially important to understand further how staff can modify their habits and routines in daily practice to involve residents and family members more. For this purpose, a multi-component approach should be developed, implemented and evaluated in co-creation with researchers, educators and practice partners to make visible and stimulate learning and improvement among nursing home staff.

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SUMMARY

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The aim of this dissertation was to investigate how relationship-centered care in nursing home settings can be enhanced. Therefore, various aspects of the work environment, data usability, and educational experiences of nursing home staff were investigated. The research questions were:

1. Which work environment factors contribute to relationship-centered working? (chapters 2 and 3)
2. How can nursing home staff be facilitated to improve relationship-centered care? (chapters 4, 5, and 6)

Chapter 1 introduces the main concepts of this dissertation: nursing homes, relationship-centered care, its practice, and the role of nursing home staff in providing it. This chapter concludes with the aim and outline of the dissertation.

Chapter 2 presents the results of a cross-sectional study on the relationship between work environment, job characteristics and person-centered care for people with dementia in nursing homes. In this study, data from the Living Arrangements for people with Dementia (LAD)- study were used. The LAD study is a cross-sectional study into quality in a broad scope of dementia care environments in the Netherlands. The LAD-study consists of a national sample of staff, clients and family members in psychogeriatric nursing homes in the Netherlands. For this study data from direct care staff (n = 552) of nursing homes (n = 49) was used. Results indicated that work environment characteristics (i.e., transformational leadership, unity in philosophy of care, teamwork and three job characteristics (social support from leader, work satisfaction and task variation and development opportunities)) were associated with staff-reported person-centered care. No statistical associations were found for other job characteristics (work conditions, social support from colleagues, autonomy and organizational commitment) and staff-reported person-centered care. The findings demonstrate that in the nursing home environment, person-centered care is influenced by organizational and work characteristics, shared values and interpersonal relationships.

In **Chapter 3**, a qualitative study consisting of semi-structured, face-to-face focus groups was conducted using the 'active dialogue approach'. This study aimed to provide insight into how nursing home staff experienced work during the COVID-19 pandemic. Themes emerging from the data were the loss of (daily) working structure, interference between work and private life for direct care staff, the importance of social support by the team and a leader, and the effects on relationship-centered care of the measures. Results offer specific implications for similar situations in the future: psychological support on-site; autonomy in daily work of care staff; an active role of a manger on the work floor and the importance of relationship-centered care.

Chapter 4 introduces an approach using narrative quality of care data in nursing homes. It used the ‘Connecting Conversations’ method that collects narratives from nursing home staff, residents and family members. The result led to a stepwise approach consisting of four steps: (1) perform and transcribe the conversations (listen); (2) calculate a valence score, defined as the mean %-positive within a triad (look); (3) calculate an agreement score, defined as the level of agreement between resident, family and nursing staff (link); and (4) plot scores into a graph for interpretation and learning purposes with agreement score (x-axis) and valence score (y-axis) (learn). Findings of this study indicated that narrative data can be used to detect similarities and differences between residents’, families’, and nursing staff’s experienced quality of care. To integrate the narrative data collected with ‘Connecting Conversations’ into an ongoing quality assurance process, it is crucial to link these calculated scores with the original qualitative data. This linkage enables a comprehensive comprehension of both the strengths and areas requiring enhancement.

In **Chapter 5** a qualitative study is presented, which explored how narrative data collected with ‘Connecting Conversations’ was used to improve relationship-centered care in nursing homes. ‘Connecting Conversations’ was used to collect the narrative data. ‘Connecting Conversations’ is a

narrative method to collect interview data from nursing home staff, residents and family members on experienced quality of care. Participating teams organized meetings on their own initiative to discuss the results of the Connecting Conversation interviews. They were responsible for organizing and determining who to invite to the meetings. The results of the 'Connecting Conversations' interviews were the main input for each evaluation meeting. Furthermore, teams were free in designing the presentation of their results.
Results show that evaluation meetings were primarily organized for care professionals. Staff and management considered it challenging to include family members and residents to reflect on the results during evaluation meetings. And if they did attend, it was challenging to achieve follow-up on formulated action points. Regarding the content of these evaluation meetings, the results of our study highlight that the narrative data were only superficially discussed during the evaluation meetings, focusing on incidental problem-solving. The full range of details and richness of the data were not used to reflect on relationship-centered care. Findings of this study indicate that improving relationship-centered care in collaboration with care professionals, family members and residents remains challenging.

Chapter 6 describes a qualitative study on how students experience learning in a hybrid learning environment and their perceptions on relationship-centered care. Within hybrid learning environments, learning and working are integrated and merged. Findings showed that students were generally satisfied with learning in the hybrid learning environment. They experienced the tailor-made learning process and actively learning in practice as motivating and pleasant. However, the connection between working and learning was not consistent, as students implied that they did not see their everyday work as part of their learning process. Regarding relationship-centered care, findings showed that students did not have sufficient knowledge of the concept. Nevertheless, they considered their way of working as highly relationship-centered. Findings suggested that the hybrid learning environment can facilitate a transition from a task-oriented approach to a relationship-oriented approach by considering certain improvement points (e.g., clarity of the role of work supervisor and students' awareness of learning while executing daily tasks).

The final chapter, **Chapter 7** summarizes the main findings followed by methodological and theoretical considerations, resulting in recommendations for further research and practice.

SAMENVATTING

Het doel van dit proefschrift was om te onderzoeken hoe relatiegerichte zorg in verpleeghuizen kan worden verbeterd. Hiervoor zijn verschillende aspecten van de werkomgeving, bruikbaarheid van data en onderwijservaringen van verpleeghuispersoneel onderzocht. De onderzoeksvragen waren:

1. Welke factoren in de werkomgeving dragen bij aan relatiegericht werken? (hoofdstukken 2 en 3)
2. Hoe kan verpleeghuispersoneel worden gefaciliteerd om relatiegerichte zorg te verbeteren? (hoofdstukken 4, 5 en 6)

Hoofdstuk 1 introduceert de belangrijkste concepten van dit proefschrift: verpleeghuizen, relatiegerichte zorg, de toepassing van relatiegerichte zorg in de praktijk en de rol van verpleeghuispersoneel in het leveren van relatiegerichte zorg. Het hoofdstuk eindigt met het doel en de opzet van dit proefschrift.

Hoofdstuk 2 presenteert de resultaten van een cross-sectioneel onderzoek naar de relatie tussen werkomgeving, functiekenmerken en persoonsgerichte zorg voor mensen met dementie in verpleeghuizen. In dit onderzoek werden gegevens gebruikt uit de "Monitor Woonvormen Dementie". De "Monitor Woonvormen Dementie" is een cross-sectioneel onderzoek naar trends in de kwaliteit van de verpleeghuiszorg voor mensen met dementie in Nederland. Dit onderzoek bestaat uit een landelijke steekproef van personeel, cliënten en familieleden in psychogeriatrische verpleeghuizen in Nederland. Voor deze studie werden gegevens van zorgpersoneel (n = 552) uit verpleeghuizen (n = 49) gebruikt. De resultaten toonden aan dat kenmerken van de werkomgeving (d.w.z. transformationeel leiderschap, eenheid in zorgvisie, teamwork en drie functiekenmerken [sociale steun van leidinggevende, tevredenheid met het werk en taakvariatie en ontwikkelingsmogelijkheden]) geassocieerd zijn met door het personeel gerapporteerde persoonsgerichte zorg. Er werden geen statistische verbanden gevonden voor andere functiekenmerken (werkomstandigheden, sociale steun van collega's, autonomie en organisatorische betrokkenheid) met door het personeel gerapporteerde persoonsgerichte zorg. Deze resultaten tonen aan dat verschillende factoren geassocieerd zijn met het leveren van persoonsgerichte zorg in een complexe setting zoals het verpleeghuis.

Een kwalitatief onderzoek, bestaande uit semigestructureerde, face-to-face focusgroepen met behulp van de 'actieve dialoogbenadering', staat centraal in **hoofdstuk 3**. Het doel van dit onderzoek was om inzicht te krijgen in hoe personeel van verpleeghuizen werken tijdens de COVID-19-pandemie ervaarden. Thema's die naar voren kwamen waren het verlies van (dagelijkse) werkstructuur, de verstoring tussen werk en privé voor zorgpersoneel, het belang van sociale steun van het team en een leider, en de effecten van de maatregelen op relatiegerichte zorg. De resultaten bieden concrete implicaties voor vergelijkbare situaties in de toekomst, namelijk psychologische ondersteuning ter plaatse; autonomie in het dagelijks werk van zorgpersoneel; een actieve rol van een manager op de werkvloer en het belang van relatiegerichte zorg.

Hoofdstuk 4 introduceert een benadering die het mogelijk maakt om met narratieve kwaliteitsgegevens te leren en verbeteren. De narratieve kwaliteitsgegevens werden verzameld met de Ruimte voor Zorg methode(:Connecting Conversations) waarbij aparte gesprekken werden gevoerd met verpleeghuispersoneel, bewoners en familieleden (driehoeken). Het resultaat leidde tot een stapsgewijze aanpak om deze gesprekken te kwantificeren bestaande uit vier stappen: (1) de gesprekken uitvoeren en transcriberen (luisteren); (2) een valentiescore berekenen, gedefinieerd als het gemiddelde %-positief binnen een driehoek (kijken); (3) een overeenstemmingsscore berekenen, gedefinieerd als het niveau van overeenstemming tussen bewoner-familie en zorgpersoneel (verbinden); en (4) scores in een grafiek plaatsen met de overeenstemmingsscore (x-as) en de valentiescore (y-as) (leren) voor duiding en inzicht in leerpunten . De bevindingen van dit onderzoek gaven aan dat narratieve gegevens gebruikt kunnen worden om overeenkomsten en verschillen tussen de ervaren kwaliteit van zorg van bewoners, families en verpleeghuispersoneel inzichtelijk te maken. Een kanttekening is dat de resultaten vervolgens gerelateerd werden aan de ruwe kwalitatieve gegevens om verdiepend inzicht te krijgen in

wat goed gaat en wat verbeterd kan worden. Deze verbinding maakt het mogelijk om zowel inzichtelijk te maken wat goed gaat als wat beter zou kunnen binnen de ervaren relatiegerichte zorg.

In **hoofdstuk 5** wordt een kwalitatief onderzoek weergegeven met het doel te onderzoeken hoe narratieve gegevens verzameld met Ruimte voor Zorg (Connecting Conversations) gebruikt worden om relatiegerichte zorg te verbeteren. Ruimte voor Zorg is een narratieve methode waarin aparte gesprekken worden gevoerd met verpleeghuispersoneel, bewoners en familieleden over de ervaren kwaliteit van zorg. Na het voltooien van de Ruimte voor Zorg interviews, organiseerden de deelnemende teams op eigen initiatief evaluatiebijeenkomsten om de resultaten te bespreken. De deelnemende teams waren verantwoordelijk voor de organisatie en de uitnodiging van deelnemers voor deze evaluatiebijeenkomsten. Bovendien hadden de teams de vrijheid om de presentatie van de resultaten zelf vorm te geven.
De resultaten lieten zien dat evaluatiebijeenkomsten voornamelijk werden georganiseerd voor verpleeghuispersoneel. Het personeel en het management vonden het een uitdaging om familieleden en bewoners te betrekken bij het reflecteren op de resultaten. Met betrekking tot de inhoud van deze evaluatiebijeenkomsten, lieten de resultaten zien dat de informatie uit de interviews slechts oppervlakkig werden besproken tijdens de evaluatiebijeenkomsten, met de nadruk op incidentele probleemoplossing. De rijkheid en details van deze verhalen werden nauwelijks gebruikt om te reflecteren op relatiegerichte zorg. De resultaten gaven aan dat het verbeteren van relatiegerichte zorg in samenwerking met verpleeghuispersoneel, familieleden en bewoners een uitdaging blijft.

Hoofdstuk 6 presenteert een kwalitatief onderzoek naar hoe studenten het leren ervaren in een hybride leerwerkplek en hun percepties over relatiegerichte zorg. Binnen hybride leerwerkplekken zijn leren en werken geïntegreerd en samengevoegd. De bevindingen toonden aan dat studenten over het algemeen tevreden waren met het leren in de hybride leerwerkplek. Ze ervaarden zowel het op maat gemaakte leerproces als het actief leren in de praktijk als motiverend en prettig. Echter, de verbinding tussen werken en leren was niet consistent, aangezien studenten aangaven dat ze hun dagelijkse werk niet zagen als onderdeel van hun leerproces. Wat betreft relatiegerichte zorg, toonden de resultaten aan dat studenten onvoldoende kennis hebben van dit concept. Desalniettemin beschouwden ze hun manier van werken als zeer relatiegericht. De bevindingen suggereerden dat de hybride leeromgeving een verschuiving van een taakgerichte benadering naar een relatiegerichte benadering kan bevorderen door rekening te houden met bepaalde verbeterpunten (bijv. duidelijkheid over de rol van de werkbegeleider en bewustwording van studenten van leren tijdens het uitvoeren van dagelijkse taken).

Het laatste hoofdstuk, **hoofdstuk 7,** vat de belangrijkste bevindingen samen, gevolgd door theoretische en methodologische overwegingen, resulterend in aanbevelingen voor verder onderzoek en praktijk.

ZUSAMMENFASSUNG

Das Ziel dieser Dissertation war es zu untersuchen, wie beziehungsorientierte Pflege in Pflegeheimen verbessert werden kann. Daher wurden verschiedene Aspekte der Arbeitsumgebung, der Nutzbarkeit von Daten und der Ausbildungserfahrungen des Pflegeheimpersonals untersucht. Die Forschungsfragen waren:

1. Welche Faktoren in der Arbeitsumgebung tragen zu beziehungsorientierter Arbeit bei? (Kapitel 2 und 3)
2. Wie kann das Pflegeheimpersonal unterstützt werden, um die beziehungsorientierte Pflege zu verbessern? (Kapitel 4, 5 und 6)

Kapitel 1 beschreibt die Hauptkonzepte dieser Dissertation: Pflegeheime, beziehungsorientierte Pflege, beziehungsorientierte Pflege in der Praxis und die Rolle des Pflegepersonals bei der Bereitstellung von beziehungsorientierter Pflege. Zum Schluss dieses Kapitels werden Ziel und Aufbau dieser Dissertation beschrieben.

Kapitel 2 präsentiert die Ergebnisse einer Querschnittsstudie über die Beziehung zwischen Arbeitsumgebung, Arbeitsmerkmalen und personenzentrierter Pflege für Menschen mit Demenz in Pflegeheimen. In dieser Studie wurden Daten aus der Studie „Living Arrangements for people with Dementia (LAD)“ verwendet. Die LAD-Studie ist eine Querschnittsstudie zur Qualität in einem breiten Spektrum von Demenzpflegeumgebungen in den Niederlanden. Sie besteht aus einer nationalen Stichprobe von Mitarbeitern, Bewohnern und Familienmitgliedern in psychogeriatrischen Pflegeheimen in den Niederlanden. Für diese Studie wurden Daten von Pflegepersonal (n = 552) aus Pflegeheimen (n = 49) verwendet. Die Ergebnisse deuteten darauf hin, dass Merkmale der Arbeitsumgebung mit der von Mitarbeitern erlebten personenzentrierten Pflege verbunden sind. Diese Merkmale sind transformationales Führungsverhalten, einheitliche Pflegephilosophie, Teamarbeit und drei Arbeitsmerkmale [soziale Unterstützung durch den Vorgesetzten, Arbeitszufriedenheit und variable Aufgaben und Entwicklungsmöglichkeiten]. Es wurden keine statistischen Zusammenhänge für andere Arbeitsmerkmale (Arbeitsbedingungen, soziale Unterstützung durch Kollegen, Autonomie und organisatorisches Engagement) und von Mitarbeitern berichtete personenzentrierte Pflege gefunden. Die Ergebnisse zeigen, dass eine Vielzahl von Faktoren mit der personenzentrierten Pflege zusammenhängen.

In **Kapitel 3** wurde eine qualitative Studie durchgeführt, die aus teilstrukturierten Fokusgruppen bestand und den „aktiven Dialogansatz“ verwendete. Diese Studie hatte zum Ziel, Einblick darin zu geben, wie das Personal von Pflegeheimen die Arbeit während der COVID-19-Pandemie erlebte. Die aus den Daten hervorgehenden Themen waren der Verlust der (täglichen) Arbeitsstruktur, die Beeinträchtigung der Work-Life-Balance des direkten Pflegepersonals, die Bedeutung der sozialen Unterstützung durch das Team und eine Führungskraft sowie die Auswirkungen der Maßnahmen auf eine Beziehungszentrierte Pflege. Die Ergebnisse bieten konkrete Implikationen für ähnliche Situationen in der Zukunft: Psychologische Unterstützung vor Ort; Autonomie in der täglichen Arbeit des Pflegepersonals; eine aktive Rolle einer Führungskraft auf dem Arbeitsplatz und die Bedeutung einer Beziehungszentrierten Pflege.

Kapitel 4 stellt eine Methode vor, die es ermöglicht, narrative Qualitätsdaten zu nutzen, um daraus zu lernen und Verbesserungsschritte zu implementieren. Es verwendete die Methode “Connecting Conversations”, die Erzählungen von Pflegeheimmitarbeitern, Bewohnern und Familienmitgliedern sammelt. Das Ergebnis dieser Studie führte zu einem aus vier Schritten bestehenden Ansatz: (1) Durchführung und Transkription der Gespräche (hören); (2) Berechnung einer Valenzbewertung, definiert als der durchschnittliche Prozentsatz an Positivität innerhalb eines Dreiecks (sehen); (3) Berechnung einer Übereinstimmungsbewertung, definiert als das Maß der Übereinstimmung zwischen Bewohner, Familie und Pflegepersonal (verbinden); und (4) Eintragen der Bewertungen in ein Diagramm für Interpretations- und Lernzwecke mit der Übereinstimmungsbewertung (x-Achse) und der Valenzbewertung (y-Achse) (lernen). Die Ergebnisse dieser Studie zeigen, dass narrative Daten

verwendet werden können, um Ähnlichkeiten und Unterschiede zwischen der erfahrenen Qualität der Pflege von Bewohnern, Familien und Pflegepersonal sichtbar zu machen. Diese Ergebnisse müssen wiederum mit den Rohdaten in Verbindung gebracht werden, um ein umfassendes Verständnis dafür zu gewinnen, was gut läuft und was verbessert werden muss. Diese Verknüpfung ermöglicht ein umfassendes Verständnis sowohl der Stärken als auch der Bereiche, die Verbesserung erfordern.

Im **Kapitel 5** wird eine qualitative Studie vorgestellt, die sich darauf konzentriert, zu untersuchen, wie narrative Daten, die mit 'Connecting Conversations' generiert wurden, genutzt werden, um beziehungszentrierte Pflege zu verbessern. Teilnehmende Teams verwendeten diese narrativen Daten, um während der Evaluierungstreffen darüber zu reflektieren. Nach Abschluss der Connecting Conversation-Interviews organisierten die teilnehmenden Teams eigenständig Treffen, um die Ergebnisse der Connecting Conversation-Interviews zu evaluieren. Die Ergebnisse der Connecting Conversation-Interviews waren die wichtigste Grundlage für jedes Evaluierungstreffen. Die teilnehmenden Teams waren für die Organisation und die Auswahl der Teilnehmer der Treffen verantwortlich. Darüber hinaus hatten die Teams die Freiheit, das Design der Präsentation der Ergebnisse zu gestalten.
Die Ergebnisse zeigen, dass Evaluierungstreffen hauptsächlich für Pflegefachkräfte organisiert wurden. Mitarbeiter und Management empfanden es als herausfordernd, Familienmitglieder und Bewohner einzubeziehen, um die Ergebnisse während der Evaluierungstreffen zu reflektieren. In Bezug auf den Inhalt dieser Evaluierungstreffen verdeutlichen die Ergebnisse unserer Studie, dass die narrativen Daten während der Evaluierungstreffen nur oberflächlich diskutiert wurden und sich vor allem auf situationsbedingte Problembehebung konzentrierten. Die gesamte Bandbreite an Details, die die Daten enthalten, wird nicht genutzt, um über beziehungszentrierte Pflege zu reflektieren. Die Ergebnisse deuten darauf hin, dass die Verbesserung der beziehungsorientierten Pflege in Zusammenarbeit zwischen Pflegefachkräften, Familienmitgliedern und Bewohnern eine Herausforderung bleibt.

Kapitel 6 enthält eine qualitative Studie darüber, wie Studierende das Lernen in der hybriden Lernumgebung und ihre Wahrnehmungen zur beziehungszentrierten Pflege erleben. In hybriden Lernumgebungen sind Lernen und Arbeiten integriert und verschmelzen miteinander. Die Ergebnisse zeigen, dass die Studierenden im Allgemeinen mit dem Lernen in der hybriden Lernumgebung zufrieden waren. Sie erlebten den maßgeschneiderten Lernprozess und das aktive Lernen in der Praxis als motivierend und angenehm. Die Verbindung zwischen Arbeiten und Lernen war jedoch nicht konsistent, da Aussagen der Studierenden darauf hindeuten, dass sie ihre tägliche Arbeit nicht als Teil ihres Lernprozesses sahen. In Bezug auf die beziehungszentrierte Pflege zeigten die Ergebnisse, dass die Studierenden nicht über ausreichendes Wissen zum Konzept verfügten. Dennoch betrachten sie ihre Arbeitsweise als sehr beziehungszentriert. Ergebnis dieser Studie zeigen, dass die hybride Lernumgebung einen Übergang von einem aufgabenorientierten Ansatz zu einem beziehungsorientierten Ansatz in der Pflege erleichtern kann, indem bestimmte Ansätze zur Verbesserung berücksichtigt werden (z.B. Klarheit über die Rolle des Vorgesetzten und das Bewusstsein der Studierenden für das Lernen während der Ausführung täglicher Aufgaben). Um beziehungszentrierte Pflege zu leisten, müssen Studierende das Konzept verstehen und Unterstützung bei der Entwicklung ihrer Reflexionsfähigkeit bekommen.

Das abschließende **Kapitel 7** fasst die wichtigsten Ergebnisse zusammen, gefolgt von theoretischen und methodologischen Überlegungen, die zu Empfehlungen für weitere Forschung und praktische Anwendung führen.

IMPACT

I

It is lunchtime at the Sunflower Nursing Home. Mrs. Janssen has been living here for two years. She knows her way around and knows all the members of staff, and this makes her feel at home. Her daughter, Anna, visits every day and helps her mother to lunch. Maintaining this routine makes them both feel good. Recently, nursing assistant Lisa have had the opportunity to schedule individual conversations with Mrs. Janssen and Anna. During this conversations they were able to talk about their thoughts, expectations, and experiences. This enabled Lisa to understand Mrs. Janssen and her daughter's relationship and how she could respond accordingly. She is now less afraid to discuss things with them, which has made her job more enjoyable. At the same time, the conversations have allowed Mrs. Janssen and Anna to make their voices heard. This has given them a sense of equality and improved their partnership with Lisa.

The above example illustrates the impact the present dissertation might have on nursing home staff, residents, and family members if its recommendations are effectively implemented. This chapter elaborates on the societal significance of the findings presented in this dissertation, detailing how the research could enhance relationship-centered care in Dutch nursing homes. Additionally, it outlines the dissemination process for these findings.

SOCIETAL IMPACT

This research was conducted within the Living Lab in Aging and Long-Term Care. [1] It has been developed from the start in collaboration with various partners associated with the Living Lab, such as long-term care organizations and partners from the educational field. The project builds on the existing methodology 'Connecting Conversations' to measure quality of care, which served as the basis for the research approach. The 'Connecting Conversations' method was also developed in cooperation with various healthcare organizations and other partners. This dissertation has contributed to the further development of 'Connecting Conversations'. The results have enriched the methodology, which is now available and being implemented nationwide.

In the Netherlands, nursing home organizations are mandated by the Quality Framework for Nursing Home Care (Kwaliteitskader Verpleeghuiszorg 2021)[2] to continually strive for improvement in their provision of quality of care. This framework underscores the importance of relationship-centered care, emphasizing that these aspects are cultivated through interactions between care professionals, residents, and their families. Future policies are trying to give more support to this effort. A new integrated policy document is currently in development, aimed at replacing the Quality Framework. It is called the Quality Compass (*Generiek kompas Samen werken aan kwaliteit van bestaan 2024*)[3] and integrates the Quality Framework for Nursing Home Care, the Long-Term Care Act for homecare (*het addendum over de Wlz-zorg thuis*)[4] and the Quality Framework for community nursing (*Kwaliteitskader Wijkverpleging*).[5] It stresses that care staff are indispensable in facilitating collaboration within the care recipient's network. The present dissertation offers guidance for nursing home organizations to help their staff in fulfilling this role. Nursing home staff can be supported by fostering teamwork and paying attention to job characteristics such as satisfaction, task variation, and development opportunities.
Furthermore, the new Quality Compass suggests that paying attention to the experiences of nursing home residents can provide a good opportunity to engage in dialogue, aiming to improve quality of care. This dissertation has investigated how narrative quality data collected with 'Connecting Conversations' can be used for quality improvement processes. These narrative data offer rich insights into the experiences of nursing home residents and a structured approach is necessary to use this data for quality improvements.
On a policy level, policy makers can use the results to implement the new Quality Compass in practice. For instance, by using 'Connecting Conversations' as one of the narrative methods to improve quality of care.[6] Results of this dissertation have been shared with policymakers, experts, and members of client councils and findings were presented in the annual report published by the Living Lab. From the start of this project, the scope and findings were also regularly discussed with a steering committee, comprising various members from practice, education, and policy. In addition, the senior advisory council (Ouderen

Adviesraad), consisting of different resident and family member representatives, has also been involved in dissemination of the findings.

Residents, families, and nursing home staff benefit from the findings of this dissertation as they are the center of relationship-centered care. By using ‘Connecting Conversations’ in practice residents are given a voice to share their experiences, collaborate and improve the quality of care. Family members are given the opportunity to actively play a role in the caring process, the collaboration with nursing home staff and in improving the quality of care. Additionally, nursing home managers are equipped with valuable insights to facilitate relationship-centered care within their organizations. The results of this dissertation highlight the importance of leaders who provide active social support, facilitate non-hierarchical teamwork and have a clear care philosophy on care provision.
The findings also provide nursing home staff with specific recommendations to better implement relationship-centered care in practice. These recommendations offer opportunities to improve collaboration with residents and family members, but also implicate a structured support for its implementation.

Moreover, findings also have implications for the education of nursing home staff. In the future, it is increasingly expected from nursing home staff to work in a relationship-centered manner. This dissertation gives recommendations for improving a hybrid learning environment in order to enhance relationship-centered care. The hybrid learning environment was established at two partner organizations, in collaboration with an educational institution. The Living Lab was tasked with monitoring developments and progress within this project. The results provided insights into what needs to be considered in order to implement relationship-centered principles in the curriculum. A short movie highlighting the dissertation’s most relevant educational findings was created in partnership with various stakeholders and distributed among the participating and other educational institutes to disseminate the findings. Additionally, findings of this dissertation were regularly presented and discussed during meetings and used in education (e.g., a movie clip was included in the curriculum for nursing home students, who were given access to ‘Connecting Conversations’ to learn how to conduct an empathetic conversation).

SCIENTIFIC IMPACT

The findings of this dissertation demonstrate the need to integrate relationship-centered care into nursing homes, particularly at the micro level (residents, their family members and nursing home staff), where relationships and collaboration need to be enhanced if the desired outcomes are to be realized.
The results of this dissertation have been shared through various channels. Three studies have been published in open-access (i.e., they are available free of charge) peer-reviewed international journals. The article on experiences and lessons learned during the COVID-19 pandemic was one of the 10 top cited articles for 2022–2023.[7] The authors have presented the findings at various national and international conferences, including the first Global Conference of Person-Centered Care (2024) in Sweden.[8]

Furthermore, several innovative aspects aimed at enhancing relationship-centered care in nursing homes contribute to the state of scientific knowledge. First, findings contribute to a more solid understanding of different work environment factors that are associated with person-centered care. These additional factors make the complex framework of person-centered care more complete.
Second, as one of the first studies conducted and published during the COVID-19 pandemic the results of the study presented in chapter 3 contributed to a better understanding of the experiences of nursing home staff during the pandemic. Furthermore, this research was part of a broader national study on the effects of measures, for instance on visitation bans during the pandemic.[9] The results also contributed to policy recommendations that were adopted internationally by other countries.[10,11] In addition, during the pandemic, Johanna Rutten (the lead researcher) volunteered in a nursing home working as a nursing

assistant affiliated with the Living Lab, thus providing active support to the nursing home staff. Third, our studies on using a stepwise approach to support the use of narrative quality data present novel ways to interpret and use narrative data. These studies give guidance on how to use these data as part of a quality improvement process. These results support the previously developed framework on experienced quality of care (INDEXQUAL)[12] and can serve as foundational knowledge for further exploration of the utilization of narrative data to enhance relationship-centered care in practice. Fourth, findings displayed that a collaboration with residents, family members and nursing home staff does not occur automatically and that this process needs a structured approach. We experimented with an open approach by refraining from intervening in the process of initiating and planning the meetings, which proved not to be entirely successful. These insights encourage additional research and innovation in this area, aimed at developing strategies that can enhance the collaboration within the care triad (resident, family member, nursing home staff).
Finally, a partnership was established in 2019 between the universities of Tilburg, Leiden, Twente, Rotterdam and Maastricht to share expertise on the use of narratives in evaluating the quality of long-term care.

To enhance the dissemination of the dissertation's findings, a factsheet including general findings of this dissertation has been created and distributed to all participating care organizations within the Living Lab. Those outside the Living Lab can access the findings through the dissertation itself or its summary, which will be posted on the Living Lab in Aging and Long-Term Care website (http://www.academischewerkplaatsouderenzorg.nl). Additionally, efforts will be made to promote the practical application of the research results.

If the results are effectively disseminated, in the future, all residents like Mrs. Janssen in the Sunflower might experience good quality of care and an equal partnership with their family members and nursing home staff.

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I

DANKWOORD

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ABOUT THE AUTHOR

A

Johanna Rutten (born Koch) was born on February 16, 1989 in Münster, Germany. In 2008 she completed secondary school at 'Gymnasium am Moltkeplatz' in Krefeld and followed a vocational training for radiographer afterwards at the University Hospital in Bonn. After completing her training and working for three years at the University Hospital in Bonn, Johanna moved to Maastricht to be with her (now) husband. She continued her career as a radiographer at the University Hospital in Aachen.

In 2015, Johanna embarked on a new academic journey, enrolling in a bachelor's program in Health Science at Maastricht University. This culminated in the successful completion of her Master's in Healthcare Policy, Innovation, and Management in 2019. Throughout her studies, Johanna remained closely connected to the healthcare sector by working as a nurse aide in a nursing home in Eijsden.

In September 2019 Johanna started working as a PhD-candidate within the 'Living-Lab Ageing and Long-Term care'. Her research focused on improving relationship-centered care in nursing homes.

Johanna lives with her husband, their two children Eric and Ella and various animals in Eijsden. For the future her desire is to build a closer connection between science and practice in the nursing home sector. After completing her PhD, Johanna will take on the role of project manager for a regional initiative in South Limburg. This project aims to facilitate a significant transition in the labor market for care professionals, helping to ensure that the workforce is better equipped to meet the evolving needs of the healthcare sector.

LIST OF PUBLICATIONS

P

International scientific journals:

Rutten, J.E.R., Heijligers, E., Erkens, P., Backhaus, R., Hamers, J.P.H., Verbeek, H., & Sion, K. Y. (2024). Students' experiences with a hybrid learning environment in nursing homes: A qualitative study. *Nurse Education in Practice*, 104078.

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Conference contributions:

Rutten, J.E.R., Backhaus. R., Verbeek, H., de Vries, E., Hamers, J.P.H., Sion, K.Y.J., We are not there yet: Enhancing relationship-centered care in nursing homes. [Global Conference on Person-centered Care mei 2024, Göteborg, Zweden]

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Rutten, J.E.R., Backhaus, R., Tan, F., Prins, M., van der Roest, H., Heijkants, C., Hamers, J.P. & Verbeek, H. (2021). Work environment and person-centered dementia care in nursing homes–a cross-sectional study. [Samenwerkende Academische Netwerken Ouderenzorg (SANO) Wetenschapsdag 2022, Leiden]

Rutten, J.E.R, Backhaus, R., Tan, F., Prins, M., van der Roest, H., Heijkants, C., Hamers, J.P. & Verbeek, H. (2021). Work environment and person-centered dementia care in nursing homes–a cross-sectional study. [19th European Doctoral Conference in Nursing Science September 2021, Bern, Zwitserland]

Rutten J.E.R., Backhaus R, Hamers J.P.H., Verbeek H., *Working as a nurse in a long-term care facility during the COVID-19 pandemic: Experiences and lessons learned*. 19. [Deutscher Kongress für Versorgungsforschung 2020, cancelled due to COVID-19]

P

LIVING LAB IN AGEING AND LONG-TERM CARE

L

LIVING LAB IN AGEING AND LONG-TERM CARE

This thesis is part of the Living Lab in Ageing and Long-Term Care, a formal and structural multidisciplinary network consisting of Maastricht University, nine long-term care organizations (MeanderGroep Zuid-Limburg, Sevagram, Envida, Cicero Zorggroep, Zuyderland, Vivantes, De Zorggroep, Land van Horne & Proteion), Intermediate Vocational Training Institutes Gilde and VISTA college and Zuyd University of Applied Sciences, all located in the southern part of the Netherlands. In the Living Lab we aim to improve quality of care and life for older people and quality of work for staff employed in long-term care via a structural multidisciplinary collaboration between research, policy, education and practice. Practitioners (such as nurses, physicians, psychologists, physio- and occupational therapists), work together with managers, researchers, students, teachers and older people themselves to develop and test innovations in long-term care.

ACADEMISCHE WERKPLAATS OUDERENZORG LIMBURG

Dit proefschrift is onderdeel van de Academische Werkplaats Ouderenzorg Limburg, een structureel, multidisciplinair samenwerkingsverband tussen de Universiteit Maastricht, negen zorgorganisaties (MeanderGroep Zuid-Limburg, Sevagram, Envida, Cicero Zorggroep, Zuyderland, Vivantes, De Zorggroep, Land van Horne & Proteion), Gilde Zorgcollege, VISTA college en Zuyd Hogeschool. In de werkplaats draait het om het verbeteren van de kwaliteit van leven en zorg voor ouderen en de kwaliteit van werk voor iedereen die in de ouderenzorg werkt. Zorgverleners (zoals verpleegkundigen, verzorgenden, artsen, psychologen, fysio- en ergotherapeuten), beleidsmakers, onderzoekers, studenten en ouderen zelf wisselen kennis en ervaring uit. Daarnaast evalueren we vernieuwingen in de dagelijkse zorg. Praktijk, beleid, onderzoek en onderwijs gaan hierbij hand in hand.

PHD-THESES LIVING LAB IN AGEING AND LONG-TERM CARE

PROEFSCHRIFTEN ACADEMISCHE WERKPLAATS OUDERENZORG LIMBURG

Johanna Rutten. Are we walking or just talking? Enhancing relationship-centered care in nursing homes. 2024.

Ines Mouchaers. Managing Everyday Life. Exploring the Essential Components of Reablement and User Experiences. 2024.

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