# The Quality Framework for Nursing Home Care

## An exploratory study towards understanding the implementation of person-centred healthcare: Which factors are involved and how do clients experience care?

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# PREFACE

You are now at the start of my thesis about the quality framework for nursing home care. I conducted an exploratory study towards understanding the implementation of person-centred healthcare: which factors are involved and how do clients experience care?

I have conducted this study for the completion of the Master program of Health Sciences at the University of Twente and with the support of Bureau HHM.

My supervisor at Bureau HHM, dr. Patrick Jansen, provided me with an interesting subject for my thesis: the quality framework for nursing home care, which was established in 2017. With this subject in mind, I have been given the opportunity to design the study by myself. Therewith I led the focus of the study on what I found the most interesting and most important.

My supervisors guided me through the research and have regularly provided me with feedback. Therefore, I would like to thank prof. dr. Jan Telgen, Marieke Weernink and Patrick Jansen for their guidance throughout the writing of my thesis.

For taking the time to letting me interview them, I would like to thank all clients, informal carers and caregivers. Next to that, I want to thank the nursing home organisations who were so kind to help me find respondents.

I would also like to thank the colleagues of Bureau HHM for their support and nice little chats, when I worked on my thesis at their office.

And last but not least, I would like to thank my family and friends for their support and feedback, especially my sister Marjolijn.

I hope you enjoy reading my thesis.

Rosemarijn Kramp
September 2018

# ABSTRACT

**Background**

Since the introduction of the Healthcare Facilities Quality Act (Kwaliteitswet zorginstellingen) in 1996, the improvement of quality in nursing home organisations has not stopped. Different frameworks for responsible care, quality documents and monitors by the Inspection for Healthcare and Youth eventually led to the introduction of the Quality Framework for Nursing Home Care in January 2017. The quality framework is mainly focused on the client. The focus of this study therefore is on the following subject of the quality framework: 'Person-centred healthcare and support'. This study's aim was to find out which factors are facilitating or impeding caregivers in the implementation of person-centred healthcare, and how person-centred healthcare is perceived by clients.

**Methods**

An exploratory study was conducted towards the factors that are involved in person-centred healthcare and how person-centred healthcare is experienced. This included desk research and semi-structured interviews and questionnaires by four different nursing home organisations. The results of the desk research were the basis for a qualitative study, where caregivers (n=18) were interviewed about the factors they experience when implementing person-centred healthcare. A second qualitative study was conducted by means of semi-structured interviews with clients (n=5) and informal carers (n=7).

**Results**

The results showed that two facilitating factors and four impeding factors are present in all nursing home organisations. This indicates nursing homes can make some improvements on the following factors: having sufficient communication about change, having a program champion, involvement of the network and having attention for patient characteristics. Clients and informal carers in general are positive about the provided healthcare and perceive it as person-centred. Improvements can be made on the agreements in the healthcare living plan, the attention towards the clients and daily activities.

**Conclusion**

This study concluded 'professional obligation' and 'personal benefits' are two facilitating factors for person-centred healthcare that are present in all studied nursing homes. Factors that were absent in all nursing homes are: communication, having a program champion, involvement of the network and having attention for patient characteristics. Results of this study cannot imply these factors are related to the implementation of person-centred healthcare. Future research is needed to validate whether factors are related to the implementation of person-centred healthcare and whether recommendations are applicable for all Dutch nursing homes.

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# INTRODUCTION

Since January 13th, 2017 the Quality Framework for nursing home care (in Dutch: Kwaliteitskader Verpleeghuiszorg) is included in the register of the Dutch Healthcare Institute (in Dutch: Zorginstituut Nederland). This framework forms the statutory basis for the quality in nursing home care (*Kwaliteitskader Verpleeghuiszorg*, 2017). The framework focuses on clients that are indicated by the 'long-term care law' (in Dutch: Wet langdurige zorg, Wlz) and it pursues a threefold objective (*Kwaliteitskader Verpleeghuiszorg*, 2017):

1. It describes what patients and their relatives may expect from the nursing home care;
2. It provides caregivers and healthcare organisations with assignments to jointly improve the quality of the nursing home care and to strengthen their learning ability;
3. It is the framework for external monitoring and for the purchasing and contracting of nursing home care.

To accomplish these objectives, the quality framework is divided into eight different themes. Four of the themes include the quality and safety of the nursing home care, the other four themes encompass the prerequisites of the quality framework. The four prerequisites include staff composition, the use of information, the use of resources and leadership, governance and management (*Kwaliteitskader Verpleeghuiszorg*, 2017).

The former state secretary of Public Health, Welfare and Sport, Martin van Rijn, wrote a letter to Parliament about the progress of the quality framework for nursing home care. He stated that, based on current insights, the framework will be fully implemented in 2021 (van Rijn, 2017). This may not be the case: recent research on the implementation of the quality framework shows that there are big differences between nursing home care organisations with regards to their implementation. There are nursing homes who already made improvements, and nursing homes who have not yet shown improvement with regard to the quality framework (Berenschot, 2017).

Because the quality framework is mainly focused on the client, this study will focus on the theme 'person-centred healthcare and support'. This study will research which factors impede, and which factors facilitate the implementation of 'person-centred healthcare and support'. Next to that, it will be studied how clients perceive the person-centred healthcare and support by the caregivers.

## 1.1 HISTORY OF QUALITY IN NURSING HOME CARE

The quality framework for nursing home care is not the first quality tool for the nursing home sector. The foundation for responsible care in Dutch healthcare facilities has been laid with the introduction of the Healthcare Facilities Quality Act (Kwaliteitswet Zorginstellingen) in 1996. To give healthcare facilities the right guidance for providing responsible care, a steering group was established in 2000. This steering group carried out a quality framework for responsible care.

One year later, the first ten quality indicators were developed. These indicators were an absolute minimum for the delivered care in healthcare facilities. Together with a management model, the indicators were further evolved into the "Assessment Framework Responsible Care"

(in Dutch: Toetsingskader Verantwoorde Zorg) in 2005. This assessment framework in turn was the foundation for the first Quality Framework Responsible Care (in Dutch: Kwaliteitskader Verantwoorde zorg), which was published in 2007 (*Samen de kwaliteit van langdurige zorg verbeteren*, 2015).

These endeavours were developed for good reason. In 2008 the Dutch Health Care Inspectorate (in Dutch: Inspectie voor de Gezondheidszorg, IGZ) published their elderly care report. This report stated that elderly care had improved structurally and that healthcare facilities provided responsible care to their clients (*Verbetering van de kwaliteit van de ouderenzorg gaat langzaam*, 2014).

You could argue that, with the offered frameworks, healthcare facilities received the tools to integrate quality in their policy. However, implementing the policy and thereby improving the quality of the delivered healthcare, has not successfully been done by all healthcare facilities.

This differentiated view was observed by the Dutch Health Care Inspectorate when monitoring care facilities from 2010 to 2011. It was caused by management changes, insufficient systematic use of care plans and insufficient alignment of the employees' skills to the needs of the clients. In their report, the Dutch Health Care Inspectorate emphasized that elderly care needs continuous improvement and has to continuously ensure their quality (*Verbetering van de kwaliteit van de ouderenzorg gaat langzaam*, 2014).

In response to the report of the Dutch Health Care Inspectorate, the former state secretary Van Rijn applied necessary changes and measures. Van Rijn presented the action plan for improving the quality of nursing homes that emerged from these measures, to the House of Representatives (in Dutch: Tweede Kamer) in February 2015. The action plan was entitled 'Dignity and pride, loving care for our elderly people' (in Dutch: 'Waardigheid en trots, liefdevolle zorg voor onze ouderen') and it was the starting point for further improvement of elderly care in The Netherlands. 'Dignity and pride' consists of five pillars: Safe care, scope to the professionals, cooperation with the client, leadership and openness and transparency. The pillar 'scope to the professionals' implies that nurses and carers will experience less hierarchy in their job. It also gives them more space to base their care plan on the capabilities of the client. This can be done by means of self-managing teams. The organisation however has to be aligned right for these teams to make them work successfully (Van Rijn, 2015).

Despite of the commitment for action plans such as 'Dignity and pride' and the development of norms and indicators for the quality frameworks, the quality in nursing home care is not met in all care facilities. That is shown in the November 2016 manifest which Hugo Borst and Carin Gaemers submitted. In this manifest they request everyone in politics to provide the best possible healthcare for vulnerable elderly in nursing homes (Borst & Gaemers, 2016).

Meanwhile, the Dutch Healthcare Institute (in Dutch: Zorginstituut Nederland) developed a new quality framework for nursing home care. As of January 1st, 2015, the reform of long-term care took place, in which the Law long-term care and the Social Support Act (in Dutch: Wet maatschappelijke ondersteuning; Wmo) replaced the General Act on Exceptional Medical Expenses (in Dutch: Algemene Wet Bijzondere Ziektekosten; AWBZ). This also resulted in a revision of the latest quality framework and -document. With the reform of the long-term care, the

government strived for three goals, which are quality improvement, more involvement from citizens and financial sustainability ("Beleid - Waardigheid en trots," 2018; van Rijn, 2014; Van Rijn, 2015). The current quality framework for nursing home care was published on January 13th, 2017 by the Dutch Healthcare Institute.

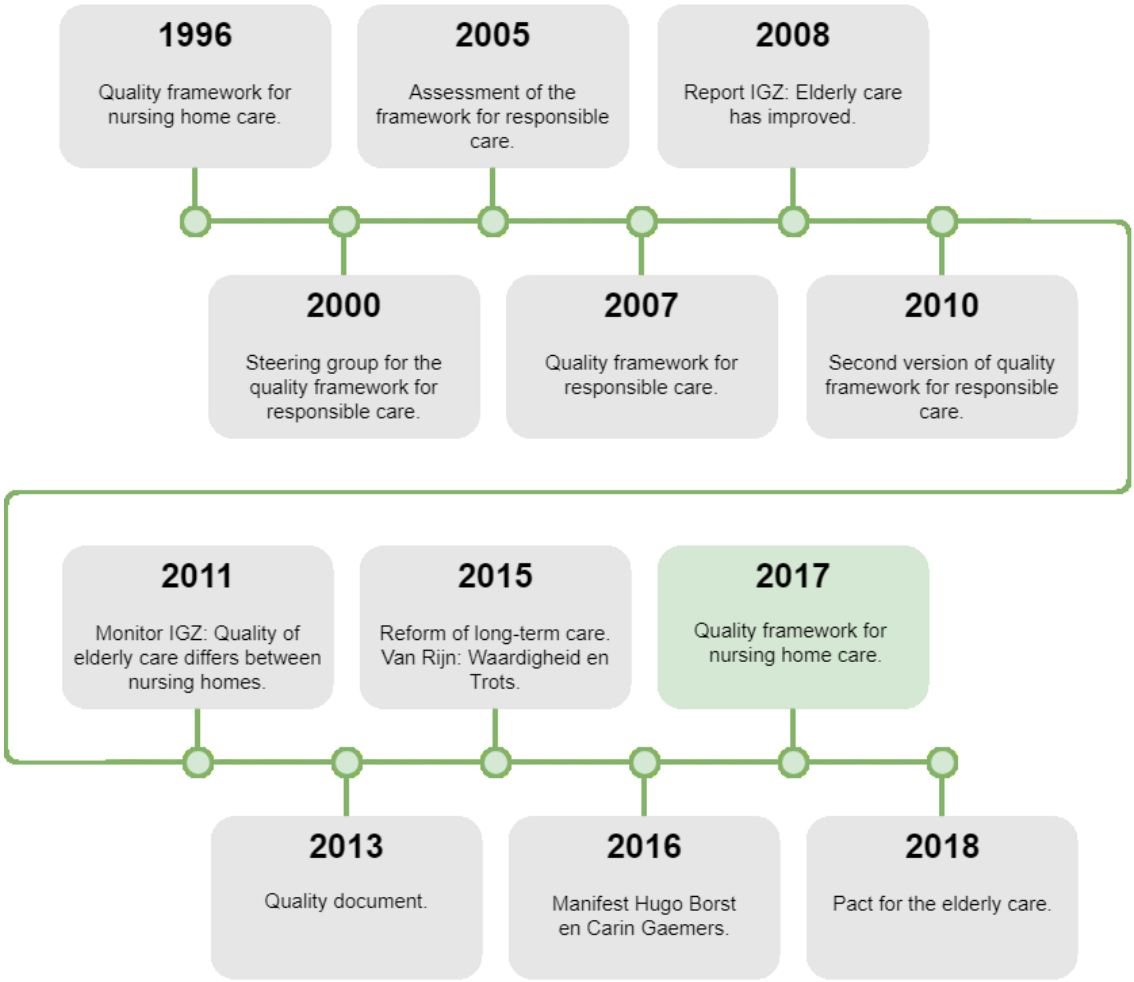


*Figure 1. Timeline Quality framework for nursing home care*

As is shown in Figure 1, the projects for improving the quality of care for the elderly people in the Netherland did not end with the quality framework. In March 2018 the current state secretary of Public Health, Welfare and Sport, Hugo de Jonge, introduced the 'Pact for the elderly care' (in Dutch: 'Pact voor de ouderenzorg') to the House of Representatives. In this pact, various parties endorse their responsibility for the quality of life of elderly people. They do so by means of three programs: perceiving and breaching loneliness, providing people the right care and support in order to live at home longer, and improving the quality of the nursing home care ("Pact voor de ouderenzorg," 2018). This pact was initially signed by 35 parties, including healthcare organisations, healthcare insurance companies, municipalities, other societal partners and the state secretary himself. After the introduction of the pact at March 8th 2018, even more parties signed it (Rijksoverheid, 2018).

## 1.2 QUALITY FRAMEWORK FOR NURSING HOME CARE THEMES

This paragraph gives a brief overview of the eight themes of the quality framework: [1] Person-centred healthcare and support, [2] Housing and welfare, [3] Safety, [4] Learning and improving of quality, [5] Leadership governance and management, [6] Staff composition, [7] Use of resources and [8] Use of information.

Apart from the framework, requirements and tasks are formulated for each theme for both the nursing home organisations and the different parties of the nursing home sector. These requirements and tasks are listed per theme in Appendix A and B respectively.

### Quality and safety themes

**Person-centred healthcare and support**

The theme person-centred healthcare focuses on four topics:

- the client needs to feel compassion from caregivers
- the client needs to feel unique
- the client must have autonomy
- the client must record his or her health aims (*Kwaliteitskader Verpleeghuiszorg*, 2017).

It is expected of every healthcare facility to develop a 'care plan' (in Dutch: zorgleefplan), together with the client and his relatives ("Zorgleefplanwijzer," 2017). This healthcare living plan contains information about the client's primary contacts and medication, but it also encloses plans for the client's spending of the day in the nursing home.

**Housing and welfare**

To improve quality in terms of housing and welfare, there is focus and support needed on five points: Meaningfulness, meaningful daily activities, a clean and cared for body and clothing, participation of the family and commitment of volunteers, and home comfort.

With these five points in mind, the caregivers in the nursing home are expected to allow clients to deploy their own (meaningful) daily activities. This can be done by accompanying a client to church, or by helping with taking a walk outside.

**Safety**

The theme safety consists of four subjects: medication safety, prevention of decubitus, motivational use of freedom-restricting measures and prevention of acute hospitalization. Indicators have been developed for each of these subjects of basic safety. Nursing home organisations are expected to record their performance on these indicators in their quality report. They are also expected to record how they are planning to improve on the indicators within all the units of the organisation (*Kwaliteitskader Verpleeghuiszorg*, 2017).

Besides the four subjects of basic safety, there are more relevant safety themes. The professional- and knowledge organisation therefore are called for making indicators for the other relevant themes (*Kwaliteitskader Verpleeghuiszorg*, 2017).

To get an overview of all incidents and errors, every nursing home organisation must have a committee for incidents or make use of a national or regional committee for incidents (*Kwaliteitskader Verpleeghuiszorg*, 2017).

**Learning from and improving of quality**

Another pillar of the quality framework is learning from and improving of quality. That is the reason why every nursing home organisation must publicize a quality plan. This plan has to be revised every year, based upon the quality report (*Kwaliteitskader Verpleeghuiszorg*, 2017).

To learn from other nursing home organisations, nursing homes must join a 'learning network'. This network must consist of at least three different nursing home organisations. Next to that, nursing home organisations must use a quality management system. As of the 1st of January 2018, all nursing home organisations have to use one (*Kwaliteitskader Verpleeghuiszorg*, 2017).

### Prerequisite themes

**Leadership, governance and management**

The management of every nursing home organisation must be supportive in improving the quality of the organisation. The board of directors has the final responsibility and acts upon the Healthcare Governance Code (in Dutch: 'Zorgbrede Governance Code'), which is an instrument that helps the board to ensure good healthcare ("Governancecode Zorg," 2017). Because members of the board of directors are expected to regularly tag along with employees, they can keep track of the quality of the delivered healthcare (*Kwaliteitskader Verpleeghuiszorg*, 2017).

The quality frameworks states that facilitating to improve the quality can be done by taking responsibility, by means of risk management and by keeping an overview of the strategic, statutory and financial obligations (*Kwaliteitskader Verpleeghuiszorg*, 2017).

**Staff composition**

The staff composition within a nursing home care facility is an important prerequisite for the delivery of good healthcare. Therefore, nursing home organisations are expected to have a sufficient workforce, in which the competences and skills of every employee are described. The intention is that every nursing home organisation evaluates its workforce yearly and includes the results in its quality report. At the end of 2018 the sector must have developed a national context-bound norm for the staff composition in nursing home organisations (*Kwaliteitskader Verpleeghuiszorg*, 2017).

To support caregivers in nursing homes in their development, feedback-, intervision-, reflection- and training opportunities will be facilitated. This can also be done by letting caregivers tag along regularly with colleagues from the learning network (*Kwaliteitskader Verpleeghuiszorg*, 2017).

**Use of resources**

To offer the best possible healthcare, every nursing home must effectively and efficiently use resources. This can also be done by sharing knowledge and evaluating healthcare process with the

learning network, and by using technological resources such as telemonitoring and eHealth (*Kwaliteitskader Verpleeghuiszorg*, 2017).

The relevant sector parties must develop a method in which the learning ability of the nursing home organisations will become visible. In that way, it can be checked whether nursing home organisations are actually learning (*Kwaliteitskader Verpleeghuiszorg*, 2017).

**Use of information**

To make further improvement in quality, it is important to gather information from the nursing home organisations about their delivered healthcare quality. To gather this information, every nursing home organisation must collect customer experiences. These have to be recorded in the quality report, together with the Net Promotor Score (NPS). The relevant parties have been given the task to develop an information standard before the 1st of January 2018. This deadline was not met in time and was extended to: 1st of September 2019.

With these themes, the quality framework does not enforce strict rules for nursing homes. It leaves the concrete implementation up to the nursing homes themselves. In any case, the implementation of the quality framework should result in good quality of healthcare for the elderly in the nursing homes. The framework was designed for the elderly in the first place, as it has the client as key principle (*Kwaliteitskader Verpleeghuiszorg*, 2017). The three themes of the quality framework that have a direct influence on the client are Person-centred healthcare and support, Housing and welfare and Safety. The other five themes are focused on the organisation and its employees and have the client as an indirect result. This is schematically shown in Figure 2.

The indicators for the theme Safety are just developed and were established in December 2017. The performance of nursing homes will be measured, based on these indicators. However, the first measurement of 2018 will be in the autumn (ActiZ, 2018). For this study, the theme Safety therefore cannot be taken into account.

The theme 'housing and welfare' is related to person-centred healthcare and support (*Kwaliteitskader Verpleeghuiszorg*, 2017). In this study it is assumed that the five topics of housing and welfare (Meaningfulness, Meaningful daily activities, Clean and cared for body and clothing, Participation of the family and commitment of volunteers, and Home comfort) are integrated in the care plan of the clients. The care plan is part of the theme person-centred healthcare and support. The focus of this study thus will be on the implementation of person-centred healthcare and support.

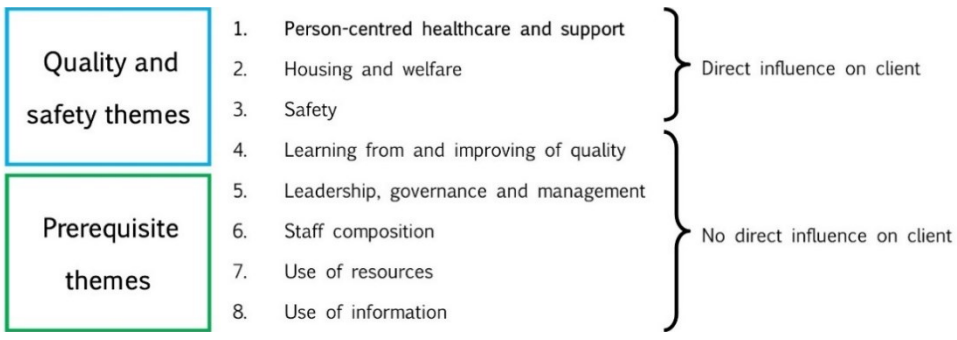


*Figure 2. Themes of the quality framework and their assumed influence on the client*

## 1.3 RESEARCH GOAL

We are now a year later since the introduction of the quality framework. It offers nursing home care organisations a foundation for making improvements in the quality of the healthcare. The implementation of the eight different themes allows nursing home organisations scope for their own interpretation. The quality framework therewith literally remains a 'framework' that can be filled in by the nursing home organisations itself. Because of the differences between nursing home organisations in among others the number of clients, management and financial operation, the implementation of the quality framework will differ for the different facilities (*Impactanalyse verpleeghuiszorg 2017*, 2017).

Consequently, identifying all results of the quality framework is difficult. The study Øvretveit (2011) conducted to understand the conditions for improvement, stated that "a number of factors influence the implementability and success of many". A literature review to the influence of context on quality found several contextual factors that are important to quality improvement (Kaplan et al., 2010). The question arises which ones are important for a successful implementation of person-centred healthcare, as stated by the quality framework.

For the introduction and evaluation of innovation processes in healthcare organisations, Fleuren, Wiefferink & Paulussen (2004) developed a framework, which is shown in Figure 3. An innovation process consists of dissemination, adoption, implementation and continuation. The framework defines four categories of determinants or factors that can positively or negatively affect these stages of the innovation process: factors of the socio-political context such as rules and legislation, characteristics of the organisation like culture and leadership, characteristics of the adopting person (user) such as skills and knowledge, and characteristics of the innovation like ease of use and compatibility.

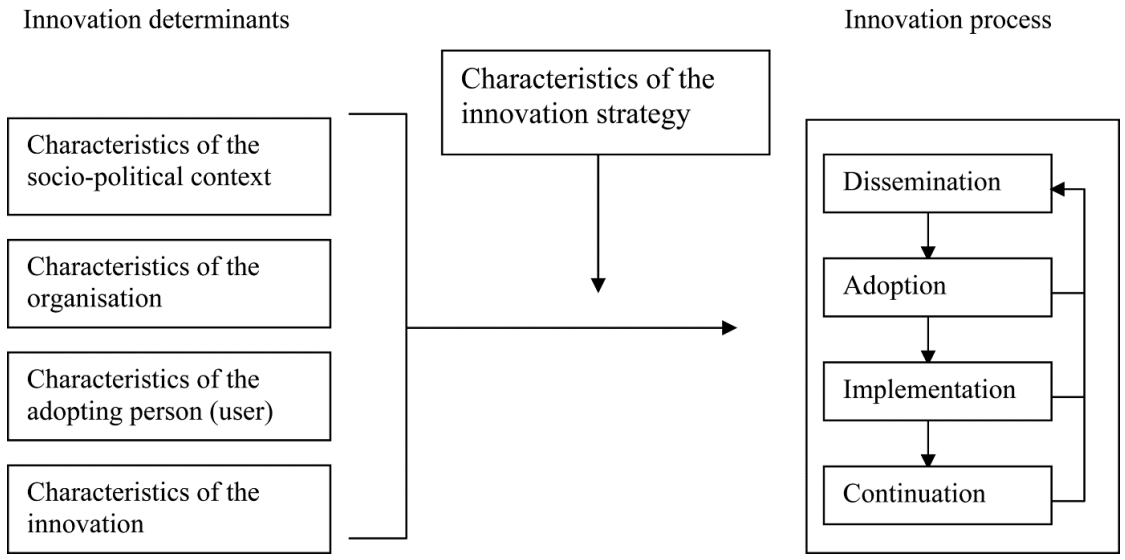


*Figure 3. Framework representing innovation process and related categories of determinants* (M. Fleuren et al., 2004).

Dutch management consulting firm Berenschot in 2017 conducted a research on the implementation of the quality framework of over sixty nursing homes. Therefore, they set out a questionnaire, mostly filled in by senior staff and policy makers, who often fulfil the role of quality officer. Next to that, they conducted in-depth conversations with managers and quality officers of nursing homes. The study shows that leadership is an important factor for successful implementation of the quality framework. Besides that, the lack of personnel is considered as a threat for quality and safety of healthcare. (Berenschot, 2017).

Because the research states that mostly senior staff and policy makers filled out the questionnaires, it is unknown whether caregivers of these nursing homes also support the factors of the study. Though, they are the ones providing healthcare according to the quality framework.

The study of Berenschot also leaves the question how the clients experience the implementation of the quality framework. Do they perceive the healthcare they've been provided with, as person-centred?

The aim of this research is to assess the factors that facilitate or impede caregivers in nursing homes to implement person-centred healthcare and support, as formulated by the quality framework. To relate these results to the implementation of person-centred healthcare in nursing homes, this research will also study the effect of implementing person-centred healthcare in nursing homes at the level of the client. This leads to the following research question:

***Which facilitating or impeding factors are present during the implementation of person-centred healthcare in nursing homes, and how is person-centred healthcare perceived by clients?***

The following sub questions together will answer the main research question.

1. **Which factors can facilitate or impede the implementation of person-centred healthcare in nursing homes?**

With answering this question, it is known which factors can facilitate or impede the implementation of person-centred healthcare in nursing homes.

Whether caregivers experience factors that facilitate or impede their implementation of person-centred healthcare, will be answered by the following question:

2. **Which facilitating and impeding factors do caregivers experience when implementing person-centred healthcare and support in nursing homes?**

Now it is known, which factors from sub question one are experienced as facilitating or as impeding by caregivers when they implement person-centred healthcare in their nursing home. Besides that, caregivers have the possibility to add factors to the list.

To study in which way the aspects of person-centred healthcare are perceived by clients and consequently, which could be improved, is answers by means of the second sub question:

3. **How do clients perceive the implementation of person-centred healthcare and support, as described in the quality framework, in their nursing homes?**

Answering this sub question, will give insight in how different aspects of person-centred healthcare are perceived by clients or their informal carers. Based on these experiences, recommendations can be given regarding improvement of person-centred healthcare by the nursing home.

Based on the answers to these questions, recommendations will be made to the managers and quality officers of nursing home organisations and their caregivers.

## 1.4 RESEARCH OUTLINE

This thesis started with an overview of the evaluation of the quality framework and its different themes. Based on that, the goal of this research and the research questions have been described. The second chapter of this thesis will describe which methods will be used for answering the research question and its sub questions. Chapter three shows the results of the sub questions. In chapter four and five, the discussion and conclusion are done. Appendices can be found in the supplementary document.

# 2 METHODS

An explorative study was conducted to answer the main research question and sub questions. The steps that will be taken to answer the research question will be described per sub question in this paragraph. All the steps are structured in one schematic overview in Figure 4.


*Figure 4. Schematic overview of methods*

## 2.1 STUDY I – FACTORS REVIEW

### 2.1.1 Study design

The goal of study I was to gather factors that facilitate or impede the implementation of person-centred healthcare. Its focus was on the following sub question: *Which factors can facilitate or impede the implementation of person-centred healthcare in the nursing home?* Desk research was conducted to gain information from different sources.

### 2.1.2 Data collection

The search for factors that can facilitate or impede the implementation of person-centred healthcare, was conducted using four different sources that are explained below: the quality framework for nursing home care, the final report of 'Waardigheid en trots', different experts and literature.

*Quality framework for nursing home care*

The first source that was searched for facilitating and impeding factors is the quality framework. This source is considered because the factors that appear in here, are specific for the quality framework. These factors were added to the table of factors.

*Final report 'Waardigheid en trots'*

The final report of the program 'Waardigheid en trots', published on the 26th of March 2018, shows different best practices on various quality subjects. As of 2016, there have been 168 nursing homes in The Netherlands working on improving the quality of healthcare for their clients. These improvements were done by means of this program. The chapters of the final report about the quality subjects 'triangle client, professionals and caregiver' and 'the client as the center' are related to person-centred healthcare. Therefore, the best practices of these subjects are searched for impeding and facilitating factors. These factors were put in the table of factors, together with factors from the quality framework.

*Experts*

To create an overall picture of factors, experts were asked for their perceptions of and their experiences with implementation of change. Experts from the Department of Change Management and Organisational Behaviour of the University of Twente, Bureau HHM, a research a consultancy organisation for (long-term) healthcare, and an integration specialist with experience in organisational change were asked to share impeding and facilitating factors. This was done by asking them two questions: "Which factors often have a positive influence on the implementation of change in an organisation, according to your experience?" and "Which factors often have a negative influence on the implementation of change in an organisation, according to your experience?" All factors that were mentioned by more than one expert, will be placed in the table of factors together with factors from the quality framework and the final report of 'Waardigheid en trots'.

*Mini literature review*

The last source is a small literature review, of which the search strategy is shown in Figure 5. Fleuren, Wiefferink & Paulussen (2004) earlier published a literature review on the determinants of implementing healthcare innovations. They reviewed existing literature from 1990 till 2000. Therefore, in Scopus literature since 2000 was searched with the following search strings: *facilitators AND barriers AND "implement* change"; "success factors" AND implement* AND "nursing home"; "Implement* change" AND (factor OR determinant) AND success AND ("health care" OR healthcare).*

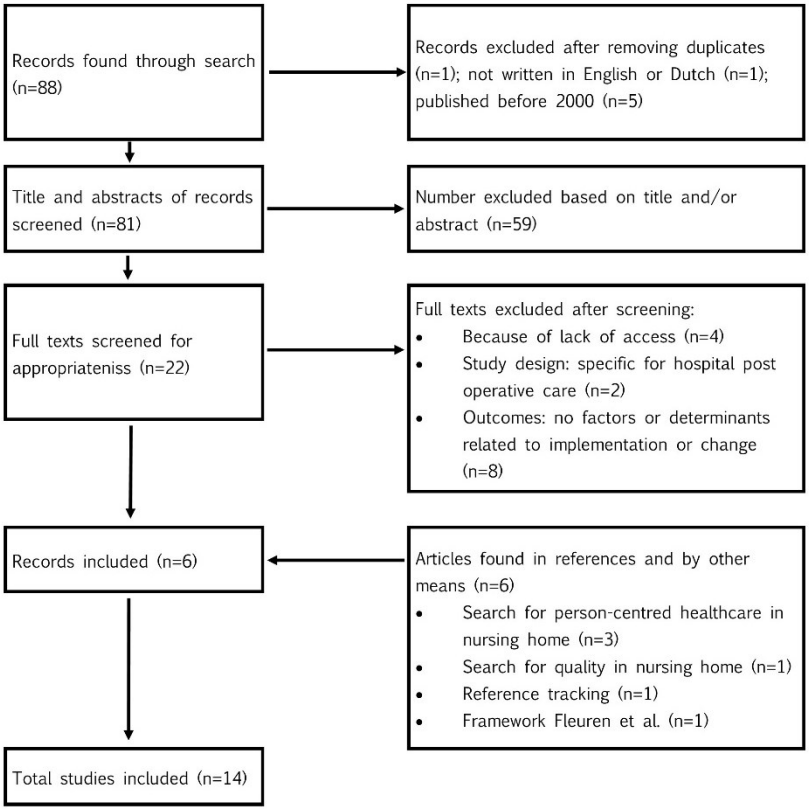


*Figure 5. Search strategy mini literature review*

Based on their title and abstract, studies were included when they covered the following inclusion criteria:

- Publication date from 2000 – present;
- Written in English or Dutch;
- It studies healthcare sector;
- It studies factors or determinants in relation to implementation or change.

Studies were excluded on the following exclusion criteria:

- Studies that did not test the relation between factors or determinants and implementation or change;
- Not applicable for nursing home.

The resulting articles were searched for factors that facilitate or impede the implementation of person-centred healthcare. All factors that were mentioned in more than one article were added to the table of factors, including the factors from the quality framework, the final report of 'Waardigheid en trots' and the experts.

For structuring the factors found in the mini literature review, the framework of Fleuren et al. (2004) was used. The factors were structured in four categories: characteristics of the socio-political context, characteristics of the organisation, characteristics of the adopting person (user) and characteristics of the innovation like ease of use and compatibility.

### 2.1.3 Data analysis

After the collection of factors, the most important impeding and facilitating factors are selected from the complete table of factors. Factors that overlap each other will be combined into one factor.

This final set of factors will be based on the following inclusion criteria:

- The factor appears in the literature review and at least one other source;
- The factor is applicable for the implementation of person-centred healthcare in nursing homes.

Criteria for exclusion:

- The factor occurs in only one of the four sources.

## 2.2 STUDY II – FACTORS EXPERIENCED BY CAREGIVERS

### 2.2.1 Design

The goal of study II is to obtain which facilitating and impeding factors are present in nursing homes when implementing person-centred healthcare and support. It was conducted to answer the third sub question: *Which facilitating and impeding factors do caregivers experience when implementing person-centred healthcare and support in nursing homes?*

The first sub question resulted in a fixed number of factors that were measured in relation to person-centred healthcare. Therefore, first semi-structured interviews were conducted with nursing home caregivers, followed by a questionnaire. Semi-structured interviews were chosen because these allow participants to elaborate on the different subjects and on information that the researcher had not previously thought of (Gill, Stewart, Treasure, & Chadwick, 2008). In this way, the researcher and participant can discuss the different factors from sub question one and participants may supplement the list of factors. To study which factors are present in the nursing home, the factors will also be measured by means of a questionnaire.

### 2.2.2 Procedures

For this study, semi-structured interviews have been conducted with 18 caregivers. The caregivers were recruited from different nursing home organisations. The nursing home organisations were invited to take part in this study by the researcher by phone or e-mail. The contact person at the nursing home organisation further invited the caregivers or provided contact information of caregivers to let the researcher to make an appointment. The recruitment was done by means of an information letter to the nursing home organisations. The information letter can be found in Appendix C and D.

All participants were informed in advance about the interview and had the opportunity to ask questions. Before the interview was conducted, the interviewer introduced the study and its goal. The participants were asked for permission to make an audio-recording of the interview. The interviews had a duration of thirty minutes to an hour, depending on the participant.

### 2.2.3 Participants

The researcher first contacted five nursing home organisations that took part in an improvement project regarding person-centred healthcare of 'Waardigheid en trots'. The contact information of these nursing homes was provided in the final report of the program 'Waardigheid en trots' (*Eindrapportage Ruimte voor verpleeghuizen - Waardigheid en trots*, 2018). One of these organisations, in this study called nursing home organisation A, agreed to participate in this study and facilitated two locations for this study: a department of the main location and a small-scale location. Both locations took part in the improvement project for person-centred healthcare.

To engage more respondents for this study, other nursing homes were contacted, among other by means of personal connections of the researcher. This resulted in the participation of nursing home organisations B, C and D. Table 1 shows the number of caregivers per nursing home.

Nursing home organisation B was a small-scale nursing home for clients who suffer from dementia. This nursing home also had taken part in an improvement project of 'Waardigheid en trots'. Their improvement project was entitled 'Family Healthcare living plan'. The aim of this project was to increase the participation of the client's family, which led to a better understanding of the client.

Nursing home organisation C was a large-scale nursing home. It consisted of different departments for somatic and for psychogeriatric patients. This nursing home is supervised by 'Waardigheid en trots' as of 2016 to manage their quality. Its aim is to affiliate the provided care to the client.

Nursing home organisation D had multiple locations, of which a small-scale location took part in this study. The quality plan of this organisation states the client is the starting point. The caregivers of this nursing home have followed a course in 2014.

The characteristics of the participants is shown in Table 1.

*Table 1. Characteristics participants Study II*

| Nursing home organisation | Number of caregivers (male/female) |
|---|---|
| **A (main location)** | 1/4 |
| **A (small-scale location)** | 0/4 |
| **B** | 0/2 |
| **C** | 0/5 |
| **D** | 0/2 |

The final set of factors from sub question one, was measured at the level of the caregivers of the nursing homes because the quality framework for nursing home care states that primary responsibility for the implementation lies with the caregivers and their nursing home organisation (*Kwaliteitskader Verpleeghuiszorg*, 2017). The director of the organisation bears the final responsibility for the whole organisation, which often consists of multiple locations. However, it was expected that not the director, but the caregivers of the nursing home organisations have the most influence on implementing person-centred healthcare and support, because they provide this care. Therefore, it is assumed that caregivers can indicate the factors that facilitate and impede them in implementing person-centred healthcare and support.

### 2.2.4 Data collection

The interviews were held face-to-face at the nursing home of the respondent. The interviews were conducted during the period of the 3rd till the 25th of July. The interview scheme in appendix D was used for conducting the interviews. The interview consisted of four parts. The first part of the interview started with general questions, about the role of the participant in the nursing home and the number of months the participant works in the nursing home. In the second part, a semi-structured interview was conducted with the participant. The improvement process of the nursing home organisation and the factors that have facilitated or impeded the implementation of this process will be discussed. The participant was also asked for additional facilitating or impeding factors that had not been discussed yet.

After the interview, the participants were asked to fill in a questionnaire. They were asked to what extent they experience the impeding or facilitating factors in the implementation of person-centred healthcare and support and how important these factors are to them. Each question about

a factor was scored on a 5-point Likert scale with the options: [1] Strongly agree, [2] Agree, [3] Neutral, [4] Disagree and [5] Strongly disagree. An example of a question is: "I feel responsible for the change towards more person-centred healthcare". The importance of each of those factors was measured on a 5-point Likert scale with the options: [1] Very important, [2] Important, [3] Moderately important, [4] Slightly important and [5] Not important.

It was chosen to formulate all questions positively, similarly to the statements for the clients. This is done because research to cognitive processes in answering questions states that alternating positive and negative formulations will lead to variance in the answers of a respondent, which will lower the reliability of the questions (Kamoen, Holleman, Mak, Sanders, & van den Bergh, 2011).

The interview will be finished with time for questions or suggestions from the participant.

### 2.2.5 Data analysis

The data from the interviews was processed anonymously. Each interview only was related to a participant number, to assure anonymity for the participants.

The semi-structured interviews were qualitatively analysed. The analysis was structured by following the sequence of the topic list. The answers of the interview were also used for quotations to strengthen the results from the questions.

The questionnaire about the factors was analysed as follows: when a question scored [1] Strongly agree or [2] Agree, the factor associated to this question was marked as present in the nursing home. When a question scored [3] Neutral, [4] Disagree or [5] Strongly disagree, the factor associated to this question was marked as not present in the nursing home. The results of these questions will be displayed in stacked bar charts, together with the importance of the factors. This will be done per nursing home. The visualization of this data will be made with Tableau software ("Tableau Software," 2018). A descriptive analysis will be done of these results.

## 2.3 STUDY III – HOW PERSON-CENTRED HEALTHCARE IS PERCEIVED

### 2.3.1 Design

The goal of study III was to find out in which way the clients in nursing homes perceive the person-centeredness of the healthcare and support, as was described in the quality framework. This was studied by means of a combination of structured and in-depth interviews with clients of the nursing homes. Study III answers the sub question: *How do clients perceive person-centred healthcare and support, as described in the quality framework, in their nursing homes?*

### 2.3.2 Procedures

For this study, semi-structured interviews have been conducted with five clients and seven informal carers. The participants were recruited from different nursing home organisations, of which two also took part in study II: the main location and the small-scale location of nursing home organisation A and nursing home organisation D.

Because clients of nursing homes have a first-hand experience of person-centred healthcare and support, it was assumed that the clients can tell it best in which way they receive this care in their nursing home. Not all clients in nursing homes were able to participate in an interview, due to their health condition or their clinical picture. When clients were not able to share their experiences of the care they receive, their informal carer was invited for the interview. It was assumed that the informal carer of the client can evaluate the care, when he visits the nursing home regularly (i.e. two times a week).

Participants were invited to take part in this study by the researcher. The recruitment was done by contacting the nursing home organisations by telephone together with an information letter by e-mail. The information letter can be found in Appendices C and D. The participating clients were asked to engage in this study by means of a contact person within the nursing home.

All participants were informed in advance about the interview and had the opportunity to ask questions. Before the interview was conducted, the interviewer introduced the study and its goal. The participants were asked for permission to make an audio-recording of the interview. The interviews had a duration of thirty minutes to an hour, depending on the participant. The interviews were held face-to-face at the nursing home of the participants. Two informal carers of the small-scale location of nursing home organisation A, participated by means of a telephone interview.

### 2.3.3 Participants

The participating clients from the main location of nursing home organisation A all had a background of psychological or behavioural problems, or a combination of the two.

The small-scale location of nursing home organisation A could engage participants in the form of informal carers. This small-scale location has its focus on clients with (early) dementia.

The other nursing home organisation engaged in this study, was nursing home D: a small-scale nursing home location. The client that participated on the account of this nursing home, suffered from Parkinson's disease and was placed in the department for somatic patients. The informal carers of nursing home D both had a mother in the nursing home who had dementia.

Their relatives were placed in the department for psychogeriatric clients. The mother of one of these informal carers had recently passed away, before the interviews was conducted.

The distribution and characteristics of the participants is shown in Table 2.

*Table 2. Characteristics participants Study III*

| Nursing home organisation | Number of Clients (male/female) | Number of Informal Carers (male/female) |
|---|---|---|
| **A (main location)** | 0/4 | 0/0 |
| **A (small-scale location)** | 0/0 | 2/3 |
| **D** | 0/1 | 0/2 |

### 2.3.4 Data collection

Wilberforce et al. (2016) reviewed measures of person-centeredness. In their systematic review they conclude that only one measurement was designed for clients of home care services to fill in. An article in which the measurement properties of this client-centred care questionnaire are studied, shows that this questionnaire had acceptable reliability values. However, respondents found the questions difficult to answer, which indicates that future measurement instruments should adjust the questions to specific circumstances of the clients (Muntinga, Mokkink, Knol, Nijpels, & Jansen, 2014). That a measurement instrument for person-centred healthcare which is valid and reliable, is not yet available, was also concluded in the review of Triemstra & Francke (2017). Therefore, it was chosen to develop a measurement instrument.

To produce a topic list for interviews to check whether clients receive person-centred healthcare, the term person-centred healthcare first was defined. The quality framework defines person-centred healthcare as "the way the client is the starting point for healthcare- and service provision in all areas of life". The goal of person-centred healthcare and support is the optimization of the quality of life of the client (*Kwaliteitskader Verpleeghuiszorg*, 2017). This description is in line with the definition of Vilans (knowledge centre for long-term healthcare) and the healthcare inspectorate (IGJ) who define person-centred healthcare as "healthcare in which the focus is on the person and not on the disability or disease". This is essential for appropriate healthcare and support (Vilans, 2018). The Dutch Healthcare Institute states that the relationship between client, family and professionals deserves extra attention in person-centred care. Next to that, the healthcare must complement the situation of the patient and to his wishes (*Samen de kwaliteit van langdurige zorg verbeteren*, 2015).

The healthcare inspectorate is responsible for the supervision of all nursing home organisations. IGJ has set up norms for providing person-centred healthcare in nursing homes. These are based on the four topics of person-centred healthcare from the quality framework: compassion, being unique, autonomy and health aims (Inspectie Gezondheidszorg en Jeugd, 2017). The norms of the IGJ for person-centred healthcare in nursing homes are:

1. Every client has a say in and has arrangements for healthcare goals, treatment and support.
2. Caregivers know the client as well as his desires, needs, possibilities and limitations.
3. Clients can take control over their life and well-being, within their own possibilities.

4. Clients experience closeness, security, trust and understanding. Clients are treated with respect.
5. Clients are supported in maintaining and/or expanding their informal network.

The IGJ formulated sample questions for assessing whether nursing home organisations meet each of the five norms (Inspectie Gezondheidszorg en Jeugd, 2017). These questions, formulated as statements, were used in the topic lists for the interviews. For each of the four sections of person-centred healthcare (compassion, being unique, autonomy and health aims) there were three statements formulated. An example of a statement is: *"The caregivers are treating me the way I want to be treated"*.

Besides the interview, a questionnaire was set up for informal carers to mark whether they agree to the statements or not. The statements had to be scored on a 5-point Likert scale with the options: [1] Strongly agree, [2] Agree, [3] Neutral, [4] Disagree and [5] Strongly disagree. The participants were also asked to indicate the importance of the statements on a 5-point Likert scale with the options: [1] Very important, [2] Important, [3] Moderately important, [4] Slightly important and [5] Not important.

All statements were positively formulated. Research to cognitive processes in answering questions states that alternating positive and negative formulations will lead to variance in the answers of a respondent (Kamoen et al., 2011). This will lower the reliability of the questions. Therefore, it is chosen to formulate all statements in one way: positively.

The interviews were conducted during the period of the 3rd until the 25th of July. The interview scheme in appendix D was used for conducting the interviews with the clients. The interview started with general questions, about the number of months the client lives in the nursing home and what the name of their nursing home organisation is.

In the following part of the interview, the respondents were asked whether they believe they are provided with person-centred healthcare and support. The interview then continued with statements about the four categories of person-centred healthcare: compassion, being unique, autonomy and health aims. Afterwards, the participants were asked for suggestions to improve the healthcare they receive. For the clients this was the last part of the interview, the informal carers were asked to fill out the questionnaire.

### 2.3.5 Data analysis

The data from the interviews was processed anonymously. Each interview only was related to a participant number, to assure anonymity for the participants. The presence and importance of the factors was analysed by means of the interviews with both the clients and the informal carers and by means of the questionnaire.

The semi-structured interviews were qualitatively analysed per nursing home organisation and -location. Next to that, the interviews were analysed separately for the clients and the informal carers. The analysis was structured by following the sequence of the topic list. The four categories were each analysed by means of their corresponding three statements. After analysing these

sections per nursing home, the results of the nursing homes were joined per section. Differences between the clients and informal carers of both nursing homes were shown.

The differences between the informal carers were also shown by means of the results of the questionnaire. These results were graphically displayed by means of stacked bar charts (Heiberger & Holland, 2015). This visualization of the data will be done by means of the software Tableau ("Tableau Software," 2018). The questions for the informal carers about receiving person-centred care that scored [1] Strongly agree or [2] Agree, were marked as "client receives person-centred care". Questions that scored [3] Neutral, [4] Disagree or [5] Strongly disagree here, were marked as "client does not receive person-centred care".

The statements that were marked as [1] Very important and [2] Important, were seen as important statements. All other response categories were unimportant statements.

# 3 RESULTS

This chapter will give the results to the three sub questions, formulated in paragraph 1.3.

## 3.1 STUDY I – FACTORS REVIEW

To identify factors that impede or facilitate the implementation of person-centred healthcare in nursing homes, different steps are taken. First, the quality framework itself was searched for factors for success. Second, the final report of 'Waardigheid en Trots' with best practices was consulted for factors. Third, experts were asked for their insights in impeding and facilitating factors. And last, literature was searched in database Scopus.

### 3.1.1 Factors from quality framework

The quality framework for nursing home care states that trust and sense of ownership are crucial in the implementation of the framework. To create trust and ownership, time, space and accompanying responsibility are required. Next to that, good support is necessary to monitor the progress of the development and implementation of the quality framework. The framework also points out that the development of learning and improving quality together is the guiding principle in the framework and the implementation of it (*Kwaliteitskader Verpleeghuiszorg*, 2017). Four themes of the quality framework are the prerequisites to satisfy the four substantive themes and the final goal: optimal quality of life for the client. These four prerequisites can be seen as facilitators for the implementation of the quality framework. The facilitating factors from the quality framework are listed in Table 3.

*Table 3. Facilitating factors from the quality framework for nursing home care.*

| **Factors** | **Facilitating** |
|---|---|
| Sufficient, skilled and competent employees | X |
| Leadership, governance and management<br>• Assign responsibility in the organisation<br>• Make decisions<br>• Risk-management<br>• Fulfil strategic obligations<br>• Fulfil statutory obligations<br>• Fulfil financial obligations | X |
| Effective and efficient use of resources<br>• Technological resources<br>• Material resources<br>• Building<br>• Financial resources<br>• Network | X |
| Active use of information<br>• Collect and use information of clients' and staff's experience<br>• Use and optimize existing administration systems<br>• Openness of the quality report | X |

### 3.1.2 Factors from final report of 'Waardigheid en trots'

The impeding factors presented in the final report are quality problems in the nursing home organisation or in the nursing home organisation and change of project leaders (*Eindrapportage Ruimte voor verpleeghuizen - Waardigheid en trots*, 2018).

Facilitating factors for the improvement processes include a learning- and improving culture of healthcare professionals; self-management of healthcare professionals in projects; awareness of caregiver's attitude and working methods on the client; improving expertise; changing behaviour; attending meetings to learn from other nursing home organisations; creating awareness about the unique needs and wishes of each client (*Eindrapportage Ruimte voor verpleeghuizen - Waardigheid en trots*, 2018).

Both impeding and facilitating factors are shown in Table 4.

*Table 4. Impeding and facilitating factors from final report 'Waardigheid en trots'.*

| Factors | Impeding | Facilitating |
|---|---|---|
| Quality problems in nursing home organisation or organisation | X | |
| Change of project leaders | X | |
| Learning- and improving culture | | X |
| Self-management of healthcare professionals in projects | | X |
| Awareness of caregiver of his attitude and working methods on the client | | X |
| Improving expertise | | X |
| Changing behaviour | | X |
| Attending meeting to learn from other nursing home organisations | | X |
| Creating awareness about the unique needs and wishes of each client | | X |

### 3.1.3 Factors from experts

Nine experts (a-i) shared their knowledge. The experts have a variety of backgrounds, including a business economist, an occupational- and organisational psychologist, a health scientist, a doctor in leadership as part of organisational change and management consultancy. This resulted in a list of impeding and facilitating factors. Table 5 shows all factors that were mentioned by more than one expert.

Four experts identify supportive management or a supportive leader as a facilitating factor for implementing change. One of the experts mentions the importance of "a management that support the change both physically and verbally". Giving attention to employees who want to change, is in line with a supportive management, and is seen as a facilitating factor. Two experts state that an absence of supportive management or leader in the organisation, is an impeding factor for implementing change.

Another factor that aligns with a supportive management is supporting reactions from employees. The working environment therefore must be safe for employees "to say it out loud when they don't agree with the change".

This factor also is mentioned as impeding, when criticism of employees is not heard.

Experts point out that it is facilitating when "all people that have influence on the change, talk about the change". In doing so, these conversations best take place "in all layers of the organisation".

Sufficient time also is mentioned as a facilitating factor for implementing change. Experts say it will be facilitating when there is "sufficient time to change" and when an "overview of time is kept".

Other facilitating factors include the change to have personal benefits for everyone involved, getting support in implementing the change from employees, a clear contribution of the change, a sufficient amount of financial resources and preparing people to change, in which an implementation strategy can help.

*Table 5. Impeding and facilitating factors by experts.*

| Factors | Impeding | Facilitating |
|---|---|---|
| Supportive management/leader | a,i | a,g,h,i |
| Support reactions from employees | b | a,c,g |
| Everyone talks about the change | | a,b,h,i |
| Personal benefits of the change | | a,d |
| Sufficient support from employees | | c,h |
| Clear contribution of change | | a,h |
| Sufficient time | | a,f,g,h |
| Financial resources | | a,g |
| Give attention to people who want the change | | a,g |
| Prepare people to change (implementation strategy) | | a,e,h |

### 3.1.4 Factors from literature review

The abstracts of 81 articles were read. Articles that studied the implementation of an innovation or a change in an organisation were included. Articles were excluded when they showed no factors related to the change or, when they were related to specific hospital settings, or when they were about the effects of an implementation. This resulted in a shortlist of 22 articles. These articles were further analysed for impeding and facilitating factors. Eventually, this resulted in 14 articles that studied one or more factors that influenced the success of the implementation of a change or innovation.

The factors from the literature review are structured according to the determinants of the framework of Fleuren et al. (2004): factors of socio-political context, factors of the organisation, factors of the adopting person and factors of the innovation. The factors that are the results of these articles are summarized in Table 6. In this table, for each factor it is shown in how many articles the factor is present.

*Factors of socio-political context*

Sommerbakk et al. (Sommerbakk, Haugen, Tjora, Kaasa, & Hjermstad, 2016) state that policy and legislation can influence the level of expertise of the staff, because of regulations that prescribe what type of professionals have to be present in care. Stange et al. (Tomoaia-Cotisel et al., 2013) also mention the political authority as an important contextual factor. Two other studies (Berta, Ginsburg, Gilbart, Lemieux-Charles, & Davis, 2013; De Veer, Fleuren, Bekkema, & Francke, 2011)

show that the perceived relevance of the change for the patient plays a role in the success of introducing the change.

Fleuren et al. (M. A. H. Fleuren, Paulussen, Van Dommelen, & Van Buuren, 2014) however state that factors from the socio-political context not often has a differentiated result, particularly when a study's focus is on one country.

*Organisational factors*

The literature review shows a wide variety of organisational factors. Berlowitz et al. (Berlowitz et al., 2003), among other studies (M. A. H. Fleuren et al., 2014; Moore et al., 2017; Sommerbakk et al., 2016), conclude in their study that the implementation of quality improvement will most likely be successful in nursing homes with a culture that promotes innovation. Leaders can play an important role in the organisational culture. Leonard, Graham & Bonacum (Leonard, Graham, & Bonacum, 2004) state that "effective leaders flatten the hierarchy, create familiarity and make it feel safe to speak up and participate". In addition to this, in the study of Øye et al. (Øye, Mekki, Jacobsen, & Førland, 2016) the involvement of the leader in the organisation is mentioned as a key factor for facilitating change. A leader that is supportive (Sommerbakk et al., 2016; Tomoaia-Cotisel et al., 2013), involves staff in the change (Øye et al., 2016; Sommerbakk et al., 2016), facilitates changes and acts as a forerunner (Moore et al., 2017; Sommerbakk et al., 2016; Tomoaia-Cotisel et al., 2013), is shown to be facilitating in implementing a change. In contrary, no support from leadership is an impeding factor.

Another organisational factor is the patient characteristics. Studies of Sommerbakk et al. and Tomoaia-Cotisel et al. (Sommerbakk et al., 2016; Tomoaia-Cotisel et al., 2013) tell that when a change is not customized to patient characteristics, this can be a barrier for the implementation of the change.

Financial support also can be critical when implementing change. Health insurers that financially support change (Tomoaia-Cotisel et al., 2013), or other funding for change (M. A. H. Fleuren et al., 2014; Sommerbakk et al., 2016; Strickland & O'Leary-Kelley, 2009), are found to be facilitating for implementing change.

Another resource that is studied to be either impeding or facilitating is time. A lack of time due to a heavy work load (Eaton, Roberts, & Turner, 2015; Øye et al., 2016) makes it difficult to implement change. Time is a facilitating factor when staff is "provided time to practice new knowledge"(Berta et al., 2013; Strickland & O'Leary-Kelley, 2009) and when everyone involved in the change is getting "finite time commitments"(Leonard et al., 2004). Next to financial resources, material resources and facilities show to be facilitating. Resources applied to training and education (Berta et al., 2013; Strickland & O'Leary-Kelley, 2009) are founded to be facilitating, even as sufficient facilities (M. A. H. Fleuren et al., 2014; Sommerbakk et al., 2016).

Organisational readiness to change is studied to be facilitating when there is sufficient willingness and capacity to change (Rosemond, Hanson, Ennett, Schenck, & Weiner, 2012) and when staff is ready to learn and to turn this into changed actions (Mekki et al., 2017). Unrest in the organisation (M. A. H. Fleuren et al., 2014), will impede the implementation process. When an organisation is ready to change, Eaton, Roberts & Turner (Eaton et al., 2015) state that a bottom-up approach is important in effecting that change. In addition, Leonard, Graham & Bonacum (Leonard

et al., 2004) tell that a medical culture should be approached from a bottom-up perspective. A bottom-up approach could be to identify a program champion, someone who has expertise about the change, guides the implementation and is available for questions (Berta et al., 2013; M. A. H. Fleuren et al., 2014; Sommerbakk et al., 2016). In that way, the change is not imposed on the employees. A facilitator in this process is getting feedback on performance by means of encouragement of sharing experiences about the new change (Berta et al., 2013; Strickland & O'Leary-Kelley, 2009), a barrier is "a low level of feedback" (Mekki et al., 2017).

One final organisational factors is involving other organisations in the implementation. This is considered satisfactory when used as a learning collaborative (Moore et al., 2017; Tomoaia-Cotisel et al., 2013).

*Factors of user/health professional*

When employees have a clear focus of what the change is about, and have "favourable perceptions about the priority of the innovation to the organisation"(Leonard et al., 2004; Rosemond et al., 2012), this is shown to be facilitating for implementing change. It will form a barrier when the change leads to competing priorities (Tomoaia-Cotisel et al., 2013).

The priority of the change can be made clear when there is sufficient communication about the change. Managers play an important role in communication by telling why changes are implemented (Berta et al., 2013; Rosemond et al., 2012). When few people are talking about the change, this will impede the implementation (Mekki et al., 2017).

Measuring the impact of the change, can work facilitating when it becomes clear the change leads to positive results (Berta et al., 2013; Leonard et al., 2004).

When there is not much willingness of individuals or teams to change, this can form a barrier (Berkhout, Boumans, Mur, & Nijhuis, 2009; M. A. H. Fleuren et al., 2014; Tomoaia-Cotisel et al., 2013). With a positive attitude towards change and with employees feeling responsible for supporting the client, professional obligation is a facilitating factor for implementing change in a healthcare setting (Berkhout et al., 2009; Eaton et al., 2015; M. A. H. Fleuren et al., 2014; Tomoaia-Cotisel et al., 2013).

In line with professional obligation is the motivation for the change. Individual professionals who are motivated to change, because of regular training or because of good results for the client, will facilitate implementing the change (Sommerbakk et al., 2016; Tomoaia-Cotisel et al., 2013).

The skills, expertise and training of staff also plays an important role in facilitating change in the healthcare setting. Skilled and educated staff are employees "who know their residents and families, and are creative in finding solutions" (Mekki et al., 2017), "who feel to be able to do what is expected"(Moore et al., 2017) and have expertise (Sommerbakk et al., 2016).

If the change is perceived to be beneficial, for instance by making the day simpler, safer and easier, this will facilitate the implementation of the change (Berta et al., 2013; Leonard et al., 2004; Sommerbakk et al., 2016). It is the other way around when staff does not see the benefit of the change for themselves (Strickland & O'Leary-Kelley, 2009).

*Factors related to the innovation/change*

An adequate innovation strategy, including education and meetings (Berkhout et al., 2009; De Veer et al., 2011; Sommerbakk et al., 2016), a written implementation plan (Berta et al., 2013) and taking the implementation step by step (Leonard et al., 2004) are facilitating factors when it comes to the implementation strategy.

When the intervention or change is easily integrated in the organisation's usual processes and clinical work, this is facilitating for the implementation(Leonard et al., 2004; Moore et al., 2017; Tomoaia-Cotisel et al., 2013). The same counts for the "extent to which the change fits with an organisation's mission, priorities and values", or the compatibility of the change (Moore et al., 2017).

A compatible intervention is one way to make the change easy to use, next to a good accessibility of the change and the use of familiar methods (Mekki et al., 2017; Sommerbakk et al., 2016).

*Table 6. Impeding and facilitating factors identified from literature.*

| **Factors** | **Impeding** | **Facilitating** |
|---|---|---|
| ***Socio-political context*** | | |
| Rules and legislation | 3 | 4 |
| Relevance for patients | 2 | 4 |
| ***Organisation*** | | |
| Culture of change in organisation | 1 | 4 |
| Supportive leadership | 3 | 7 |
| Patient characteristics | 2 | 1 |
| Financial resources | 1 | 4 |
| Sufficient time | 4 | 4 |
| Material resources and facilities | 1 | 4 |
| Organisational readiness for change | 1 | 3 |
| Bottom-up approach of change | - | 2 |
| Involving network in change | 2 | 3 |
| Identify a program champion | 2 | 3 |
| Performance feedback | 2 | 3 |
| ***User/health professional*** | | |
| Priority of the change | 1 | 2 |
| Professional obligation | 5 | 4 |
| Knowledge and skills | 3 | 8 |
| Motivation for the change | 1 | 2 |
| Communication about change | 2 | 4 |
| Personal benefits of the change | 3 | 5 |
| Measure impact of change | 1 | 3 |
| ***Innovation*** | | |
| Implementation strategy | 4 | 8 |
| Ease of use | 3 | 3 |
| Compatibility | 2 | 6 |

### 3.1.5 Final set of factors

It is concluded that there is evidence on the effect of various factors on the implementation of a change. The complete set of factors of all four sources is to be found in Appendix F. Based on the inclusion criteria, the following factors are included: Relevance for patients; Culture of change in organisation; Supportive leadership; Financial resources; Sufficient time; Material resources and facilities; Involving network in change; Identify a program champion; Professional obligation; Knowledge and skills; Communication about change; Personal benefits of the change; Measure impact of change; Implementation strategy.

In Table 7, it can be seen in which data source besides the literature, a factor was mentioned.

*Table 7. Selection of factors.*

| Included | Literature | Experts | 'Waardigheid en Trots' | Quality framework |
|---|---|---|---|---|
| | | | | |
| 1. | **Rules and legislation** | | | |
| | Relevance for patients | | X | |
| 2. | **Culture of change in organisation** | | X | |
| 3. | **Supportive leadership** | X | X | X |
| | Patient characteristics | | | |
| 4. | **Financial resources** | X | | X |
| 5. | **Sufficient time to implement change** | X | | |
| 6. | **Material resources and facilities** | | | X |
| | Organisational readiness for change | | | |
| | Bottom-up approach of change | | | |
| 7. | **Involving network in change** | | X | X |
| 8. | **Identify a program champion** | X | | |
| | Performance feedback | | | |
| | Priority of the change | | | |
| 9. | **Professional obligation** | X | X | |
| 10. | **Knowledge and skills** | | X | X |
| | Motivation for the change | | | |
| 11. | **Communication about change** | X | | |
| 12. | **Personal benefits of the change** | X | | |
| 13. | **Measure impact of change** | | | X |
| 14. | **Implementation strategy** | X | | |
| | Ease of use | | | |
| | Compatibility | | | |

These fourteen factors were all stated in the literature review and one of the other sources. The factors Rules and legislation, Patient characteristics, Organisational readiness for change, Bottom-up approach of change, Performance feedback, Priority of the change, Motivation for change, Ease of use and Compatibility were excluded.

## 3.2 STUDY II – FACTORS EXPERIENCED BY CAREGIVERS

This study will answer the second sub question: *"Which facilitating or impeding factors do caregivers experience when implementing person-centred healthcare and support in nursing homes?*

This paragraph will start with showing the characteristics of the study population. After that, the interviews with the caregivers and the questionnaire they filled in, will be analysed. This analysis is structured in the fourteen factors that resulted from Study I.

### 3.2.1 Study population

18 Caregivers have been interviewed from two different nursing home organisations. All respondents (n = 18) finished the whole interviews and filled out the complete questionnaire. The interview codes of the respondents, and the distribution of the caregivers over the different nursing home organisations, can be found in Table 6. All quotes of the caregivers can be found in Appendix G of the supplementary document.

Table 8 shows that four different nursing home organisations (A, B, C and D) participated in this study. Nursing home organisation A facilitated two locations: one department of the main location and a small-scale location.

*Table 8. Characteristics of the study population of caregivers*

| Interview code | Nursing home organisation |
|---|---|
| **C01** | A: Department of main location |
| **C02** | A: Department of main location |
| **C03** | A: Department of main location |
| **C04** | A: Department of main location |
| **C05** | A: Department of main location |
| **C06** | A: Small-scale location |
| **C07** | A: Small-scale location |
| **C08** | A: Small-scale location |
| **C09** | A: Small-scale location |
| **C10** | B |
| **C11** | B |
| **C12** | C |
| **C13** | C |
| **C14** | C |
| **C15** | C |
| **C16** | C |
| **C17** | D |
| **C18** | D |

### 3.2.2 Caregivers' experience of factors

This section will provide the results of both the questionnaire and the semi-structured interviews.

The results of the questionnaire are shown in Figure 6, per nursing home organisation. The x-axis shows the number of records, the y-axis shows the fourteen different factors. The different colours indicate whether the respondents completely disagreed (dark red), disagreed (light red), were neutral (grey), agreed (light green) or completely agreed (dark green).


*Figure 6. Presence of factors in nursing homes according to caregivers.*

**Person-centred healthcare**

None of the respondents disagreed to the statement 'Do you provide person-centred healthcare?', as can be seen in Figure 7. However, only all respondents of nursing home A (small-scale), B and D (completely) agreed to it.

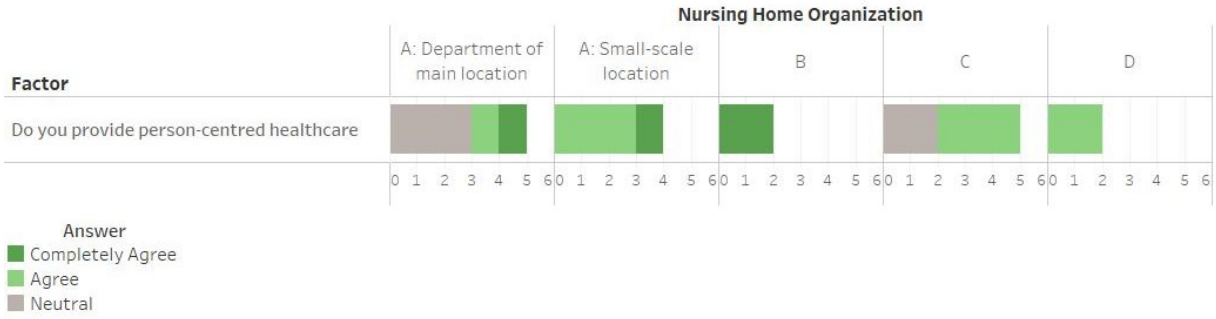


*Figure 7. Caregivers answer to 'Do you provide person-centred healthcare?'*

The caregivers of nursing home organisations A (main location) and C that did not agree nor disagree with the statement, have different reasons for that. The available time, variation in working methods between colleagues and the target group of the nursing home were mentioned:

- *"I think it's difficult with dementia patients. Because people sometimes do not know what makes them unique anymore (Interview C05)."*
- *"But it varies between colleagues. One colleague does it in a different way, the other are more direct. (…) And the other does it differently. Basically, everyone works to the wish… client-centred, in a different way. And for me, that is a little bit of a problem." (Interview C13)*

In the interviews it stands out that the caregivers of the small-scale location of nursing home organisation A believe they are able provide person-centred healthcare, because they do have or make the time for it (Interviews C06, C07).

**Factor 1: Relevance for patients**

During the interviews, all respondents agreed to the fact person-centred healthcare is of relevance for the clients, and all respondents found this factor (very) important. The outcome of the questionnaire in Figure 6 however, shows two 'neutral' answers for the small-scale location of nursing home organisation A and nursing home C. Respondents of the small-scale location of nursing home organisation A, attribute the difficulty of answering this question to the clinical pictures of the clients of their location:

- *"It's difficult to answer. There are people who experience every day as a new one, they don't know where they are. These people won't recognize me. There are people who do recognize me, and they still have their own perception of things (Interview C08)";*
- *"A resident enjoys things really in the moment. Because of their dementia, they quickly forget what you've been doing with them, or what you've been talking about (Interview C09)."*

**Factor 2: Culture of change in organisation**

The answers of the questionnaire show that the caregivers of nursing home A (small-scale) and B agree to having a culture of change. This indicates the factor is present in these nursing homes. In the interviews with respondents of these nursing homes however, some remarks are given on the factor. One caregiver states that change always leads to resistance (Interview C08) and it is mentioned that not everyone is eager to change (Interviews C09, C10). This reasoning is also seen in the interviews with caregivers of the other nursing home organisations.

Another argument mentioned is the fact there might be a culture of change, but at the moment not towards person-centred healthcare (Interviews C16, C18).

**Factor 3: Supportive leadership**

None of the respondents disagreed to the statement of having supportive leadership for person-centred healthcare. However, there was agreement of all respondents for only two nursing home organisations: A (small-scale) and B.

In the small-scale location of nursing home organisation A, the caregivers felt the support of the healthcare manager in two ways: (…) putting a lot of hard work at a higher level to get an extra training (Interview C06) and by recommending improvements for our working method (Interview C07). Aspects of a supportive leader that were mentioned by caregivers of the different nursing home organisations were having an open character, being available for personal matters and helping out at the department when necessary.

The fact that some caregivers did not disagree nor agree with the statement, can be due to the fact the leader's support is *"not necessarily for person-centred healthcare (Interview C04)"* or because they simply don't know what their leader is doing at the moment (Interview C18)

**Factor 4: Financial resources**

Whether the organisation uses financial resources for person-centred healthcare, was answered as 'neutral' by half of the caregivers. Only both the respondents of nursing home organisation B agreed to the presence of this factor, insinuating this factor is present.

The caregivers that did agree with the statement, know their organisation uses financial resources for education (Interview C01), renovating the nursing home (Interview C10) or with attracting more personnel in the form of hands-on caregivers (Interview C15) and voluntary workers (Interview C18).

In the interviews it came forward that many caregivers just don't know whether their organisation uses their financial resources specifically for person-centred healthcare

**Factor 5: Sufficient time**

Three out of eighteen respondents disagreed with the statement of having sufficient time to provide person-centred healthcare. Only all respondents of the small-scale location of nursing home organisation A agreed to having sufficient time.

The results of the interviews however did not paint a too rosy picture of the factor 'sufficient time'. In nursing home organisations A (main location), B and C understaffing was mentioned. According to the respondent of Interview C10, the workload gets bigger for others as

a result of understaffing. Next to that, there are more flex workers needed (Interviews C12,C13,C15,C16) which take time from the caregivers as well:

- *"If you don't have flex workers, we do have a sufficient amount of time. With flex workers, I'm the only responsible person. It takes more time to explain all kind of things about your residents to flex workers, than when you have your 'own' personnel (Interview C15)."*

That it is important to take the time for providing person-centred healthcare to the target group of dementia patients, is mentioned by different caregivers of the different nursing home organisations (Interview C02, C04, C08, C16, C17).

- "*If I'm nervous and I'll approach the residents in a hurry, the residents get frightened. That's not my intention (Interview C08)."*
- *"It's way more quick when you can just explain it to someone. When you can't explain it, like in here, with people who suffer from dementia, you have to take the time for it (Interview C16)."*

**Factor 6: Material resources and facilities**

Despite of the fact there were negative points mentioned in the interviews, none of the respondents disagreed with the fact the organisation has sufficient materials and resources for providing person-centred healthcare. However, of all nursing home organisations at least one respondent gave a neutral answer, except from the respondents of nursing home B.

Negative points mentioned by caregivers of nursing home organisations A (both locations) and C were the small bedrooms and two-person-bedrooms that clients had (Interview C01, C06, C09, C13, C16). However, the small but therefore cosy and homeliness atmosphere of the small-scale location of nursing home organisation A is also believed to be an advantage (Interviews C08, C09).

In contrast, the caregivers of nursing home organisation D think the spacious apartments of their nursing home are an advantage. Hence, there are different opinions on what is best and most person-centred for the clients. The respondent of Interview C06 seems to have an idea about that too: *"I think we could take a targeted look at the people: what triggers them from the past, what things do they recognize. I think we should take a closer look at that kind of things. Like having an old-fashioned clock, making use of cup and saucer when drinking coffee, that kind of stuff. For that matter, we can make a change."*

**Factor 7: Involving network in change**

All nursing home organisations had at least one respondent who did not (completely) agree to this factor. Additionally, there are two disagreements from caregivers of nursing home organisation C. In the interviews all respondents of this nursing home did not know whether the organisation provided it or had never asked about it.

Only one respondent of the main location of nursing home organisation A marked a 'Neutral' for the presence of this factor in the questionnaire. The other respondents all agreed, whereas all caregivers in the interview stated they did not know whether the organisation provides them in visiting another nursing home.

All caregivers of the small-scale location told they'd visited another nursing home organisation and stated it's possible to do courses for person-centred healthcare. One of the courses the caregivers mentioned, was Specialized Psychogeriatric Nursing. Despite the agreement in the interviews, two respondents marked the factor's presence as 'Neutral'.

Caregivers from nursing home organisation B and D both stated their organisation won't stimulate them to have a look at another nursing home, because due to the understaffing "*they are scared you'll walk away (Interviews C10, C18)".*

The importance of this factor for person-centred healthcare is however not endorsed by all respondents. It was marked as (very) important by 11 respondents, seven did not. One respondent found it not important at all. Some respondents don't seem to think it would make a difference:

- *"It's really fun to have a look in another nursing home and get some new ideas. But in practice, it doesn't really work. Every nursing home has its own identity. Every nursing home has its own methods, so it's a little bit difficult I think (Interview C08)".*

**Factor 8: Identify a program champion**

For all nursing home organisations, at least one respondent did not (completely) agree to having this factor present. The respondents that did agree, mainly referred to their healthcare coordinator (C02, C03) or manager (C07, C09, C13, C15, C16) as their first contact point. The consultant for experience-based care, mentioned in Interview C08, was only consulted in problematic cases. A contact point specifically for person-centred healthcare, was not mentioned.

The respondents often commented that they discuss how to provide the healthcare in a person-centred way, with each other, as caregivers (Interviews C01, C09, C10, C11, C14, C15).
Having one program champion for person-centred healthcare, then was mentioned to be (very) important by 12 caregivers, six did not. One respondent found it not important at all.

**Factor 9: Professional obligation**

All respondents of all nursing home organisations personally felt responsible for providing person-centred healthcare. Consequently, this factor is present in all nursing homes, according to the respondents.

In Interview C05 the respondent stated why she finds it so important to provide person-centred healthcare by the following example: "*Yes, and especially on other departments. Clients from another department would never say themselves if they want to wear a necklace, for example. Whereas the family of the client does find it important that she wears a necklace. When family comes by to visit the client, they see their family member as she is, with necklace. I find that important."*

The caregivers of nursing home organisation D emphasized the responsibility they have for their own department, because they work on the department on their own.

**Factor 10: Knowledge and skills**

The two 'neutral' answers of the main location of nursing home organisation A stand out in Figure 6. However, not all respondents of this location had finished their education yet. In addition,

respondent C01 stated the knowledge and skills could be improved when everyone gets the extra education she had a few years ago.

All other nursing home locations agreed to having sufficient knowledge and skills for providing person-centred healthcare. Consequently, the factor 'knowledge and skills' is present in these nursing homes. Yet, where the answers of the questionnaire only show 'Agree' and 'Completely Agree' for the small-scale location of nursing home A, the interview did not. Two respondents of this location stated in the interview that their skills for providing person-centred healthcare can be improved: *"(…) I do not know enough yet. I always can learn more, and I'm willing to (Interview C09)."*

According to different respondents, factors for having the right knowledge and skills for providing person-centred healthcare are life and work experience (Interviews C02, C03, C08, C10, C13, C15) even as having a heart for the job (Interviews C07, C08, C13, C18).

**Factor 11: Communication about change**

Each nursing home at least had one respondent who did not agree to the presence of the factor 'communication about change'. The two disagreements of nursing home organisation A (main location) and nursing home C stand out in the results of Figure 6.

The other caregivers of the main location of nursing home organisation A and C namely do believe there is communication about person-centred healthcare, for example by means of healthcare plans (Interviews C01, C02, C13, C15) or by discussing how to change and make the healthcare more person-centred (Interview C03). Respondents C14 and C16 communicate by conveying to work person-centred themselves.

The respondents of nursing home organisations A (small-scale) and B that do communicate with colleagues about person-centred healthcare, do so by exchanging ideas for improvement (Interviews C06, C08, C11).

From the interviews, it was notable that the caregivers of nursing home organisation D, did not have transfers included in their working shifts. When caregivers do not want to do the transfer in their own time, communicating about healthcare happens on paper. Team meetings happen once in the two months (Interview C18).

**Factor 12: Personal benefits of the change**

All caregivers of all nursing home organisations (completely) agreed on paper of having personal benefits when providing person-centred healthcare. This factor thus is present in all nursing homes. It was often heard that respondents mentioned it to be nice when the clients react in a happy way (C01, C02, C03, C04, C10, C11, C16, C17).

One of the respondents of nursing home organisation B does not find it important whether she gets personal benefits from providing person-centred healthcare.

**Factor 13: Measure impact of change**

Nobody disagreed on paper to the statement of knowing whether the clients find the healthcare person-centred. But only all respondents of nursing home organisation A (small-scale) and D marked the factor as present in their nursing home.

Regardless of the presence of this factors, some difficulties in measuring the impact of person-centred healthcare were mentioned face-to-face: Because of the clinical picture of dementia people quickly forget what they did (Interview C17) and it's difficult whether they can give their own view (Interview C11). An example of that was given in Interview C17: *"Last week, we organized a high tea. Afterwards you'll ask the residents whether they liked it and they look at you and say: 'had what?'. As we just left the high tea. But they can't remember it afterwards."*

Other respondents state to not specifically ask their clients and get to know their clients' opinion by their interaction with the client (C02, C03, C08, C10, C11, C17, 18) or because the clients tell it themselves (C07, C09, C15). Respondent C08 had another specific reason for not asking her clients how they feel about the care they've been given: *"But it's quite confronting when you have to come and live here. Because you've lost your home, you might had to sell it, your children will clear your house. So, why should I confront the clients with the fact that they're living in a nursing home? By asking them? (…) So, I think it's better to not confront the clients with it."*

**Factor 14: Implementation strategy**

Nursing home organisation B was the only one of which both respondents agreed to the presence of the factor 'Implementation strategy'. The opinion on this matter differs for the respondents of the other nursing homes.

One answer stands out in Figure 6, and that is the answer 'Completely Disagree' by a respondent of nursing home organisation C. After the interview, this respondent coincidentally bumped into the researcher, telling that "in the past there had been a plan for providing person-centred healthcare, but apparently the plan completely diluted". One colleague of her stated the organisation is trying to get more hands-on caregivers, but doesn't know whether that belongs to a plan of providing person-centred healthcare.

Respondents C01, C09, C17 and C18 associate the implementation plan with the education they previously had, whereas respondents C02 and C11 associate it to the healthcare living plan in which all agreements for the clients are stated.

### 3.2.3 Factors that are present in the nursing homes

The factors which all caregivers (completely) agreed to, were present in all nursing home organisations. Thus, according the respondents, the factors 'professional obligation' and 'personal benefits of change' were present. The factors that were absent in all nursing homes, included 'involving network in change', 'identify a program champion', 'communication about change'.

In Figure 8 it can be seen which factors occur in which nursing home, by the green squares. The gray squares indicate the factor is absent in a nursing home.

The number of present factors in the nursing home differ per nursing home organisation. The two locations of nursing home organisation A for example, show different factors that are present and a different number of present factors (three and seven). Both locations were involved in the improvement project for person-centred healthcare of 'Waardigheid en trots'.

Nursing home organisation B also was involved in an improvement project, focused on involving the client's family into the healthcare living plan. The caregivers of this nursing home, showed that nine factors are present in their organisation.

Nursing home organisation C has not specifically been involved in a project for person-centred healthcare. Their caregivers stated to have three factors present in the organisation.

Caregivers of nursing home organisation D did follow a course regarding experience-centred healthcare in 2014. There are five factors present in their organisation.

| | Nursing home organization | | | | | |
|---|---|---|---|---|---|---|
| Factor | A main | A small-scale | B | C | D | # nursing homes with factor present |
| Relevance for patients | ■ | ■ | ■ | ■ | ■ | 3/5 |
| Culture of change in organisation | ■ | ■ | ■ | ■ | ■ | 2/5 |
| Supportive leadership | ■ | ■ | ■ | ■ | ■ | 2/5 |
| Financial resources | ■ | ■ | ■ | ■ | ■ | 1/5 |
| Sufficient time | ■ | ■ | ■ | ■ | ■ | 1/5 |
| Material resources and facilities | ■ | ■ | ■ | ■ | ■ | 1/5 |
| Involving network in change | ■ | ■ | ■ | ■ | ■ | 0/5 |
| Identify a program champion | ■ | ■ | ■ | ■ | ■ | 0/5 |
| Professional obligation | ■ | ■ | ■ | ■ | ■ | 5/5 |
| Knowledge and skills | ■ | ■ | ■ | ■ | ■ | 4/5 |
| Communication about change | ■ | ■ | ■ | ■ | ■ | 0/5 |
| Personal benefits of change | ■ | ■ | ■ | ■ | ■ | 5/5 |
| Measure impact of the change | ■ | ■ | ■ | ■ | ■ | 2/5 |
| Implementation strategy | ■ | ■ | ■ | ■ | ■ | 1/5 |
| # factors present in nursing homes | 3/14 | 7/14 | 9/14 | 3/14 | 5/14 | |

*Figure 8. Number of factors present in the nursing homes.*

## 3.3 STUDY III – HOW PERSON-CENTRED HEALTHCARE IS PERCEIVED

This study answers the third sub question: *"How do clients perceive person-centred healthcare and support, as described in the quality framework, in their nursing home?"*

This paragraph will first show some characteristics of the study population. Afterwards, person-centred healthcare will be analysed by means of the perception of the clients and the informal carers. The analysis follows the four different topics: Compassion, Being Unique, Autonomy and Health Aims.

### 3.3.1 Study population

There were five clients interviewed in this study, and seven informal carers (n = 12). Four clients were located in a department of the main location of nursing home organisation A. All clients in this department have a background of psychological or behavioural problems, or a combination of the two. The other client was located in a small-scale nursing home of organisation D, where she was located on the department for somatic patients.

The informal carers that participated in this study, were from the small-scale location of nursing home organisation A. This location has its focus on clients with (early) dementia.

A short overview of the characteristics of the study population is shown in Table 9. This table shows that two different nursing home organisations (A and D) participated in this study. Nursing home organisation A facilitated two locations: one department of the main location and a small-scale location.

The quotes of all clients and informal carers can be found in respectively Appendix H and I of the supplementary document.

*Table 9. Characteristics study population study III.*

| Interview code | Nursing home organisation | Type |
|---|---|---|
| **CL01** | A: Department of main location | Client |
| **CL02** | A: Department of main location | Client |
| **CL03** | A: Department of main location | Client |
| **CL04** | A: Department of main location | Client |
| **IC01** | A: Small-scale location | Informal carer |
| **IC02** | A: Small-scale location | Informal carer |
| **IC03** | A: Small-scale location | Informal carer |
| **IC04** | A: Small-scale location | Informal carer |
| **IC05** | A: Small-scale location | Informal carer |
| **IC06** | D | Informal carer |
| **IC07** | D | Informal carer |
| **CL05** | D | Client |

### 3.3.2 Clients and informal carers their experience of person-centred healthcare

The following section will provide the results from the interviews with the clients and the informal carers. Their responses will be processed separately, as the clients have only been interviewed, whereas the informal carers also filled out a questionnaire next to the interview.

The results are structured in five sections, starting with person-centred healthcare. The other four sections include the topics of person-centred healthcare, namely: compassion, being unique, autonomy and health aims.

#### *3.3.2.1 Person-centred healthcare*

**Clients**

Two of the four respondents of nursing home organisation A (main location) did not agree to the statement of receiving person-centred healthcare. Respondent CL02 stated "*The care is not always as I want to. The caregivers are often busy*".

The respondent of nursing home organisation D stated: *"Well, I make sure that happens (…) You can't make everybody happy in this nursing home. Because the one person needs to be animated, the other wants to watch André van Duin, whereas another person wants to watch sports throughout the day (Interview CL05)."*

**Informal carers**

All informal carers agreed to the fact their relative is receiving person-centred healthcare, matching the wishes and needs of their relative. Two respondents of the small-scale location of nursing home organisation A, compliment the nursing home because of that: *"(…) This nursing home, it's a pearl. It sounds funny, because it doesn't look that great, it's small and it's old. But there are a few things that are really good (Interview IC04)."*

However, informal carers of nursing home organisation A (small-scale) and D also remark the difficulty of satisfying the wishes and needs of clients:

- *"She does not have a lot of wishes anymore. You have to guess what she likes. When you ask her what she wants, she doesn't talk a lot anymore (Interview IC05)".*
- *"My mother didn't have any clue at the moment. She really was far in her process of dementia and she couldn't really express her wishes and needs (Interview IC06)".*

The questionnaire's first and last statement about person-centred healthcare, was identical. One respondent however answered these questions differently, as can be seen in Figure 9. First, she completely agreed with the statement, and the second time she agreed.

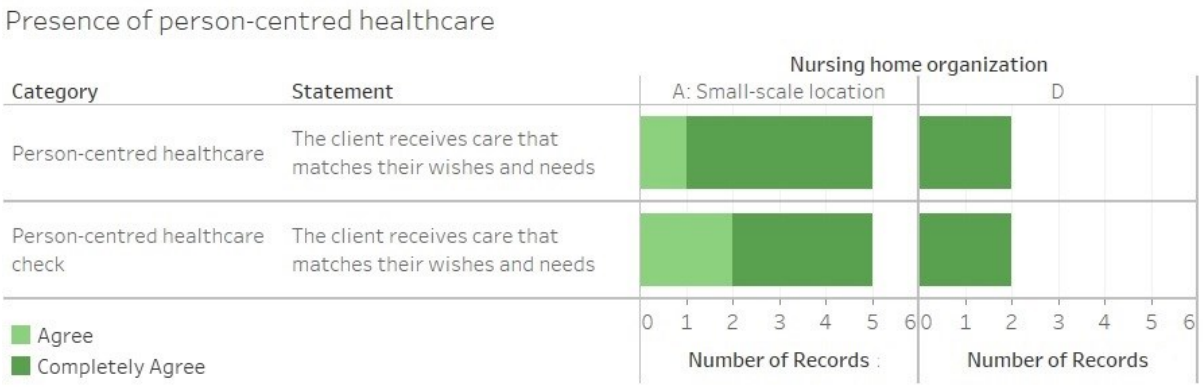


*Figure 9. Presence of person-centred healthcare.*

### *3.3.2.2 Compassion*

**Clients**

All clients of nursing home organisation A (main location) were positive about the subject compassion. One respondent emphasized the attention caregivers have: *"When necessary, the caregivers will sit next to my bed throughout the night (Interview CL04)."*

The client of nursing home organisation D was positive about the way her caregivers approach her, but had some remarks: *"I make sure they do. When I don't agree with something, I'll tell them. (…) For example, everything has to be mashed for me, because I've some problems with my teeth. (…) But the one person is more eager to do so then the other (Interview CL05)."*

**Informal carers**

With regard to the subject compassion, the informal carers of both the nursing homes were positive as a whole. The visualization of this subject can be seen in Figure 10. The way in which the people wanted to be approached by the caregivers, was asked at the intake of the clients in the nursing home, according to the informal carers of both the nursing home organisations. However, this part of compassion was not marked as important by two informal caregivers of nursing home organisation A (small-scale).

All informal caregivers felt that caregivers treat their relative as they want to. Although there were some remarks on that:

> *"(…) there is a comment on that. Sometimes, she doesn't want to do something and then she has to be motivated. We agreed on that with the nurses, that now and then, the nurse motivates her to do things. (…) My mom despises showering, probably due to the dementia. But it has to happen. Let's say you have to encourage her to do so then. (Interview IC02, IC07)."*

Regarding the statement of giving attention to the clients, all informal carers but one (completely) agreed. One informal carer could not agree nor disagree with that. She stated *"a little more attention would be nice (Interview C01)"* and thinks it's due to the fact of understaffing. The respondent of Interview IC03 also noticed there is one nurse less than before.

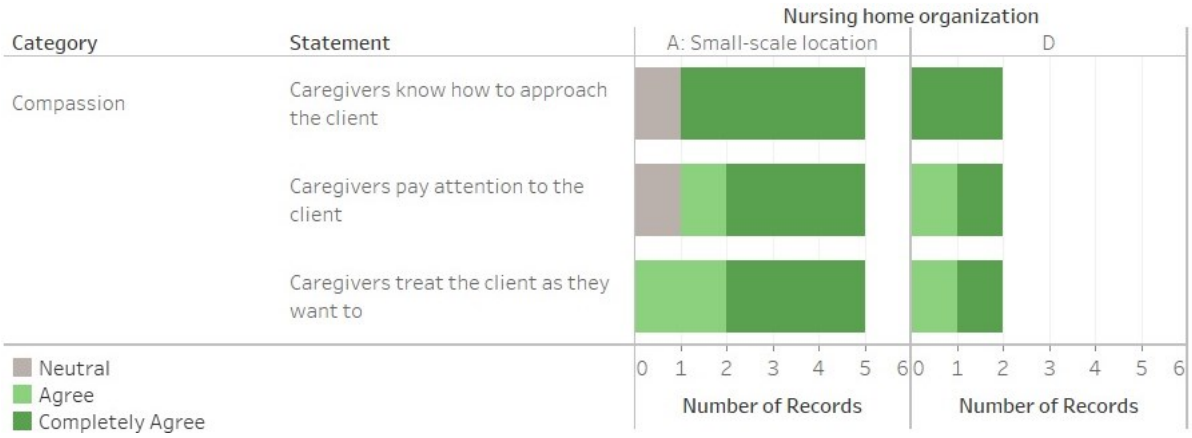


*Figure 10. Presence of 'Compassion'.*

#### *3.3.2.3 Being unique*

**Clients**

All clients were positive about two statements regarding the topic 'being unique': They all agreed to the statement that caregivers are informed about their life history and the statement that caregivers know what makes them happy and what doesn't. Although the caregivers know about it, not all clients found it important that the caregivers know about their life history (Interviews CL01, CL02).

Regarding the client's preferences for the schedule of the day, the answers were mainly positive. However, two clients indicate that they would like to have the possibility to shower more than once a week (Interviews CL03, CL05).

**Informal Carers**

With regard to the topic 'being unique', the answers to the statement about knowing the life history of the clients, stand out. This can be seen in Figure 11. Two of the informal carers of nursing home organisation A (small-scale) did not agree with this statement. Next to that, responses regarding the importance of this statement show that two of the five respondents mark it as important. The respondents also mentioned they don't feel the need for caregivers to know everything about their relative's past (Interviews IC02, IC05) in the interviews.

All informal carers (completely) agreed to the other two statements regarding the topic 'being unique'.


*Figure 11. Presence of 'Being Unique'.*

#### *3.3.2.4 Autonomy*

**Clients**

The clients of both nursing home organisations agreed to the fact their caregivers know what they can do on their own, and to the fact their caregivers let them do these things. Clients of nursing home organisation A (main location) gave the example of helping with cooking, doing the dishes (Interviews CL02, CL03, CL04) and being able to do some of the personal care by their selves (Interviews CL04, CL05). However, one remark on autonomy is made by the client of Interview CL05. She namely finds it very difficult to be so dependent. She told that it's harsh to lay in bed in the morning, not knowing who will get you out of bed today, and when.

Where the clients of nursing home organisation A (main location) state there are plenty of option for daily activities, the client of nursing home organisation D does not. She doesn't mind though: *"Fortunately, no. For me there isn't. (…) I don't want to be entertained. I've got my books, I like to tinker. (…) I love to read, tinker, embroidering. (…) I'm enjoying myself."* However, she does notice other residents of her department would love to have some more activities:

**Informal Carers**

The statement about the caregivers knowing what their relative can do on their own was answered positively, even as the statement that caregivers let their relatives do the things they can do by themselves. This can be seen by the bar chart in Figure 12. Examples of things their relatives do themselves are helping out with cooking and helping out with the dishes (Interviews IC01, IC03 and IC05). Other examples include dressing themselves and brushing their teeth (Interviews IC02, IC03 and IC05, IC07).

Anyhow, one respondent thinks the caregivers could let her mother do a little more: *"For example, taking care of the plants or set out something in the living room or the dining room (Interview IC01)."* According to the respondent of Interview IC05, it differs per caregiver: *"The one caregiver will let the people do a lot by themselves, the other will outsource everything."*

Another remark on the first two statements was made by the respondent of Interview IC06: *"from the start, she couldn't do very much. (…) She was too far in her process of dementia. In the beginning she could walk with the walker, but only back and forth in the hallway. Helping with things, she couldn't do anymore."*

With regard to the daily activities conducted by the nursing home, the respondents differ. Where five respondents agree, two of nursing home organisation A did not. One of the two also said that he found it a difficult statement: *"(…) because actually there is not much to do. But that has to do with the location, and with my mother. When you offer her something, nine times out of ten she'll tell you she doesn't feel like it. (…) It's difficult because of the disease process. (…) How can you give somebody a meaningful day in here? That's what I find difficult (Interview IC02)."*

The respondent of Interview IC06 remarked that there sometimes is a lack of time, due to the fact there's only one nurse for six residents, who also have a lot of administration to do.

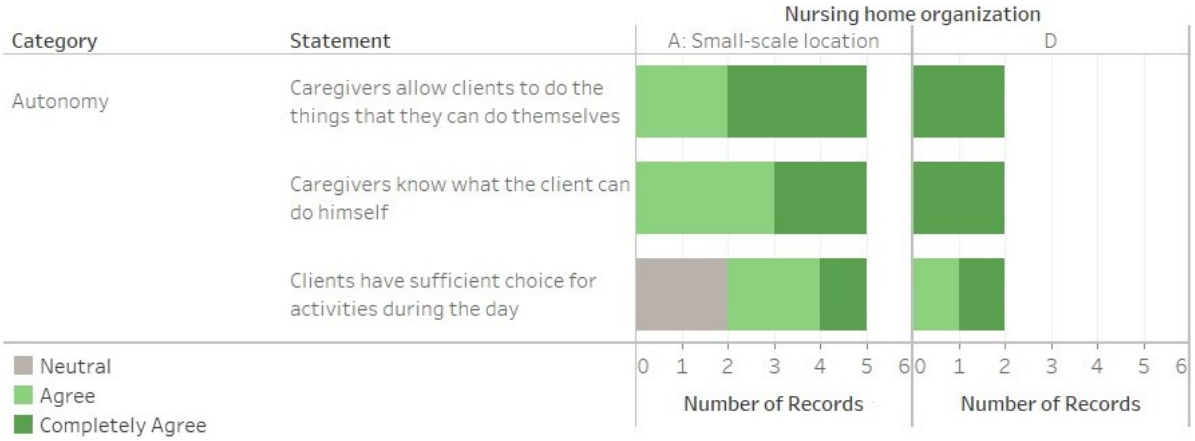


*Figure 12. Presence of 'Autonomy'.*

### *3.3.2.5 Health aims*

**Clients**

All clients of nursing home organisation A's main location knew about the existence of the healthcare living plan. However, the content of this healthcare living plan was not always known by the clients, which makes it difficult for them to say whether they recognize themselves in the plan.

Two of the clients (Interviews CL02, CL03) do think that the caregivers follow the agreements made in the healthcare living plan. One client states *"they do not always fulfil the agreements, because it is not always possible ( Interview CL01) ."*

The client of nursing home D has a different view on whether agreements are made: *"No. I really miss rules. Like: we're having breakfast at 8:00, having some bread at 12:00. (…) There are no precepts."*

She also wondered whether they really know about her wishes and gives the following example: "*Well. This morning for example I got bouillon because my salt concentration has to go upward. But they still ask whether I would like to have a coffee, but I don't drink coffee! I don't understand that they still don't know that I don't drink coffee. They do know some rules, but executing them… (Interview CL05)."*

**Informal Carers**

The bar chart in Figure 13 shows there were no disagreements on the statements about the agreements made about their relative. It was heard that the agreements are adjusted twice a year (Interview IC02, IC04, IC05, IC07).

The respondents stated there is not much about the past of the client in the healthcare living plan. To the statement whether they recognize their relative in the healthcare living plan, two respondents did not agree, nor disagree. Not all respondents found this statement important: four of the seven respondents marked it as moderately important, one as important and two as very important.

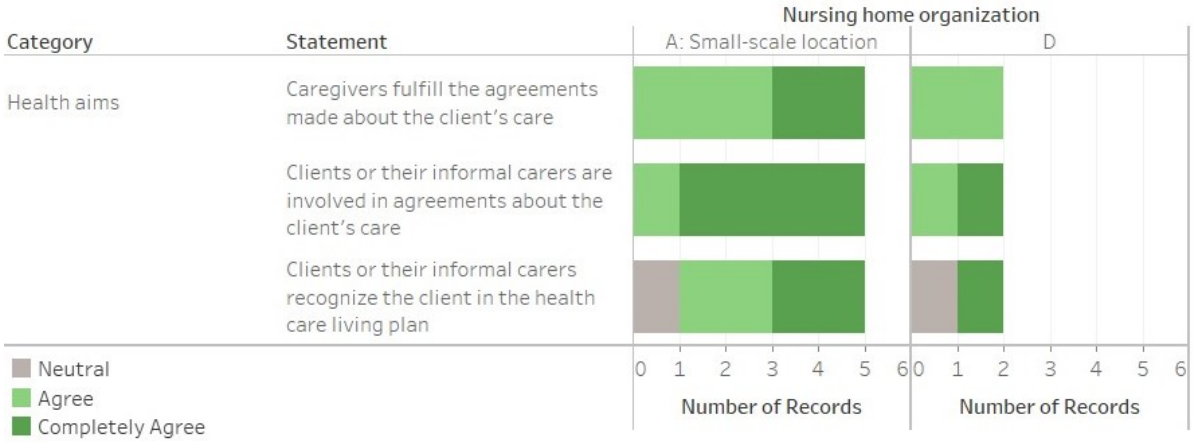


*Figure 13. Presence of 'Health Aims'.*

# 4 DISCUSSION

The Dutch population is ageing throughout years. From 1996, when the Healthcare Facilities Quality Act was established, until 2018, the population of people from 65 years and older has increased by over 1.2 million people ("CBS StatLine," 2018). However, the number of people living in nursing home organisations, has decreased because people now longer live at home (Campen et al., 2017). This is due to among others the reform of the long-term care in 2015, stating that only the elderly with severe health problems are allowed in nursing home organisations. Before 2015, elderly were also allowed with less severe health problems.

For the caregivers of the current nursing home organisations, this has been a transition as well. Their healthcare now is more focused on the severe health problems, as before the health problems were not that complex. For them, it is a challenge to keep the healthcare they provide, person-centred.

With the results of this study's factors review, interviews with clients, informal carers and caregivers of different nursing homes, and a short questionnaire, the facilitating and impeding factors that are present during the implementation of person-centred healthcare in nursing homes will be found. With discussing how person-centred healthcare is perceived by clients and informal carers, a view at the state of the implementation of person-centred healthcare in nursing homes is given.

The discussion will first describe a summary of the main findings, after that relations between these findings and earlier research will be discussed. Furthermore, it will state the strengths and limitations of this study and lastly discuss recommendations for practice.

## 4.1 SUMMARY OF MAIN FINDINGS

This study showed that different facilitating and impeding factors are experienced by caregivers of nursing home organisations. The factors 'professional obligation' and 'personal benefits of the change' were the only two factors that were marked as present by all respondents of all nursing home organisations. These two factors thus are experienced by all caregivers. About the factor 'professional obligation', caregivers stated that they really feel responsible for providing the healthcare in a person-centred way, with the remark they do not always have time for it.

The factors that were not experienced by all nursing home organisations were: 'involving network in change', 'identify a program champion' and 'communication about change'. Every nursing home had at least one respondent who marked these factors as 'not present'.

The factor 'patient characteristics' did not make it to the final set of factors. However, the respondents often mentioned they had to adjust to the patient characteristics. Caring for someone with dementia requires other skills than caring for someone with Parkinson, for example. Therefore, it is important for caregivers to keep adjusting to the patient wishes and needs, in order to make the healthcare as person-centred as possible.

However, the presence of two factors and the absence of four factors in all nursing home organisations does not imply these factors are related to the implementation of person-centred healthcare. Because nursing home organisation A specifically did an improvement project on person-centred healthcare, it is expected that their implementation of person-centred healthcare is carried out well. This however is not evident from the results, which do not show many present factors in this nursing home organisation. The results also show a different number of present factors for the two locations of this nursing home organisation.

The number of present factors of the main location of nursing home organisation A is equal to the number of factors present at nursing home organisation C, namely three. This is striking because nursing home organisation C had not specifically shown plans for person-centred healthcare, whereas nursing home organisation A did.

The results regarding the presence of the factors in the nursing home do not align with the fact that a nursing home organisation is working on the subject person-centred healthcare and support.

With regard to the perception of person-centred healthcare and support by clients, the interviews showed a diverse picture. Though all topics of person-centred healthcare were positively evaluated, there also were remarks. In general, the clients were positive about the topic compassion. They are all nicely approached by their caregivers and four out of five clients were positive about the attention they get. Some improvement can be made on providing the care to the clients, in a way they like. For example, one client was not happy about the agreements made about going to the toilet: one client felt that caregivers are often busy and another client does not think caregivers are eager to help her smash her food.

As a whole, the clients are positive about the caregivers seeing them as a unique person, for example by knowing what the hobbies of the clients are. One remark was the fact that some clients only get to shower once a week. For that matter, clients would like to be heard more by the caregivers.

The clients also report to having sufficient autonomy. The caregivers let clients do the daily care that they could still do on their own. As an example, in one nursing home clients helped cooking and doing the dishes. One client however stated that it's difficult to be so dependent and not knowing when and by whom you will be getting helped out of bed in the morning. On that case, more agreements could be made.

Two of the five clients did not know exactly what is in their healthcare living plan. Because of different reasons, clients do not always think the caregivers fulfil all the agreements made. Therefore, there could be made some improvements on both the expectations of the clients and the agreements made by the caregivers.

This diverse picture, with different opinions of the clients, shows that each client experiences the provided healthcare in a different way. Where the one client does not believe the healthcare is person-centred because she does not like the agreements made about visiting the toilet, the other does experience person-centred healthcare by personal attention of the caregiver. And where the one client does think it is important their caregivers know about their life history, other clients do

not. Because of these differences, it is difficult to determine at the level of the client, whether person-centred healthcare is provided. Assessing to what extent person-centred healthcare is provided, might be done in a more subjective than objective way. Therefore, it is essential to know what these wishes and needs of each individual client include.

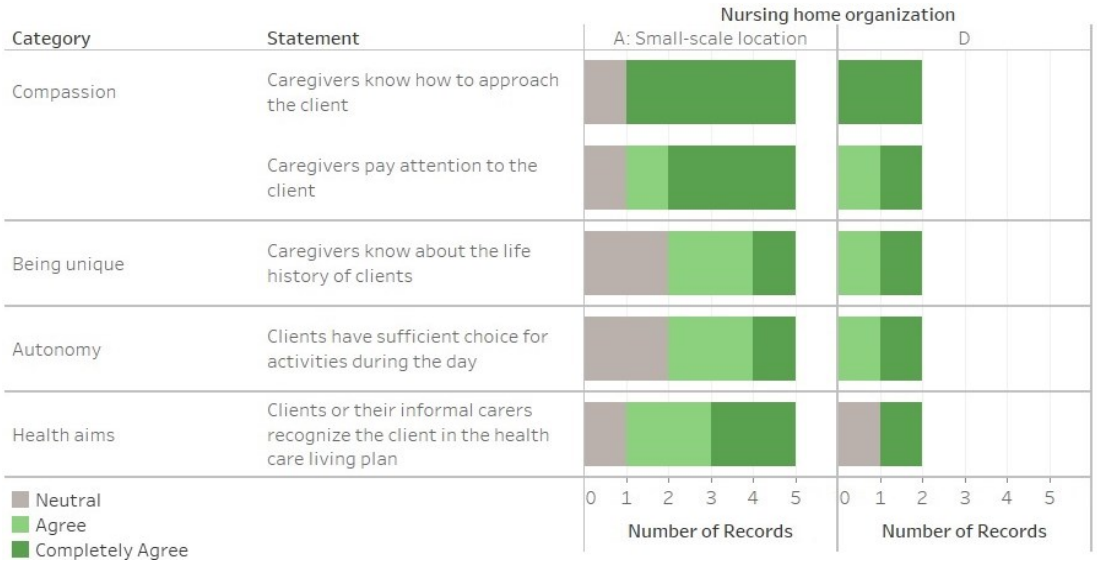


*Figure 14. What can be improved, according to informal carers.*

The informal carers also had some differences in their opinion of the different topics of person-centred healthcare. As a whole, they (completely) agreed to the fact their relative receives person-centred healthcare, which is care that matches their wishes and needs. The differences appear when the different topics of person-centred healthcare come up. In Figure 14, the questions that did not have an agreement of all five informal carers, can be seen. This indicates there can be made improvements on the account of approaching the client, having attention for the client, knowing about the life history of the client, sufficient daily activities, and the healthcare living plan.

However, the respondents do not call for an improvement of all these subjects. Because the respondents that did not (completely) agree, in some cases found the statements only slightly or moderately important. Which indicates the informal carer don't seem to think the subject is that big of a deal. This was the case for approaching the client and knowing the life history of the client.

The cases which the informal carer that did not agree to, but does find it very important it does happen, are:

- Caregivers pay attention to the client, where the informal carer stated to find it;
- Clients have sufficient choice for activities during the day;
- Clients or their informal carers recognize themselves in the healthcare living plan.

With regard to nursing home organisation D, it can be concluded that one of the two respondents did not believe her relative could be recognized in the healthcare living plan. She did however find it very important.

## 4.2 COMPARISONS WITH OTHER STUDIES

Earlier research of the Social and Cultural Planning Office (in Dutch: Sociaal en Cultureel Planbureau) to the experienced quality of life and healthcare of elderly in nursing home and care home facilities, showed that in general, residents are positive about autonomy and the way they are being approached. Next to that, the research recommends more personal attention and to give more insight in how the agreements with the clients are fulfilled.(Campen et al., 2017). This study is in line with those results. The research of Campen et al. (2017) also recommends nursing home organisations to focus more on facilitating person-centred healthcare, in their policy. And that is where this study has a new addition, with interviewing caregivers of different nursing homes about facilitating and impeding factors when implementing person-centred healthcare.

With regard to the study of Berenschot, this study adds the experience of caregivers, clients and informal carers. Where Berenschot mainly involved the top layers of the nursing homes, this study laid its focus on the people who directly are involved in person-centred healthcare and support.

Next to that, Berenschot did their research towards the implementation of the quality framework as a whole, this research focuses on one topic of the quality framework: person-centred healthcare and support. The research of Berenschot showed that leadership is an important factor for successful implementation of the quality framework, and that the lack of personnel is considered as a threat for quality and safety of healthcare (Berenschot, 2017). The lack of personnel was also mentioned by different caregivers in relation to this study. However, in a research conducted at the Maastricht University, it was concluded that there is no evidence that the number of personnel is directly linked to the quality of the healthcare (Hamers, Backhaus, Beerens, Van Rossum, & Verbeek, 2016). However, it does imply that nursing home organisations should focus on an optimal mix of employees.

## 4.3 STRENGTHS AND LIMITATIONS

To the best of the researcher's knowledge, the implementation of person-centred healthcare, as stated by the quality framework, has not yet been studied at the level of both clients, informal carers and caregivers. Analysing the results of clients and informal carers separately, showed the differences between those two groups. Where clients receive their healthcare 24 hours a day and are dependent of this care, informal carers only see a glimpse of the healthcare their relative is provided with. This exploratory study, in which the interviews with the different respondent groups gave an insight in the experiences of both giving and receiving person-centred healthcare, is a strong point of this research. One informal carer indicated the questions of the interview and the questionnaire are really what the care is all about. This indicates that at least one informal carer agrees to the fact that the four different topics of person-centred healthcare, all are important.

However, this study does have limitations, which should be considered when interpreting the results of this study.

One limitation is that the recruitment of respondents could have causes selection bias, because the respondents were not randomly chosen. The contact person of the different nursing

homes namely invited the respondents in the first place. This bias was also recognized by the researcher. A number of caregivers that were interviewed, namely stated that they do provide person-centred healthcare, but colleagues of them do not. It might be the case that the researcher only got to interview the caregivers that felt the most responsible for providing person-centred healthcare.

Another limitation is related to the analysis of the data. Because the researcher was on her own, the data was only interpreted by her. That could have led to mistakes in the interpretation of the data and a lack of objectivity. This could have been prevented by letting the researcher keep a daily journal, in which all interpretations and thought regarding the interview would have been stated, or by involving other researchers in the data analysis.

The results from the interviews with the respondents sometimes differed from the answers they gave in the questionnaire. Based on the results, it is presumed that respondents tend to answer the questionnaire positively, or questions have been interpreted in a different way. To prevent this from happening again, the researcher could let the respondents fill out the questionnaire at first, and then could ask for the explanation of the answers in the interview. Based on that, adjustments to the questionnaire can be made as well.

A final limitation is related to respondents. The perception of person-centred healthcare of informal carers, is based on the time they spend in the nursing home and what they hear from their relative. And despite the fact interviewing clients fits in the subject of person-centred healthcare and support, the results of some of the clients should be interpreted with some caution. Some respondents had a background for psychiatric or behavioural problems, and therefore their truth may differ from the actual truth. Though this does not detract in any way the experience of the clients.

The answers of the clients and informal carers cannot fully be generalized for all nursing home organisations. That has to do with the differences in interpretation of the healthcare they receive. What can be generalized is the fact that every client is different, and therefore it is important for caregivers to provide the care person-centred, to the needs and wishes of every individual client.

Regardless of the limitations of this study, this research is providing useful information about facilitating and impeding factors for implementing person-centred healthcare in nursing homes. It provides a basis for other studies to build on.

## 4.4 RECOMMENDATIONS

Based on the interviews with caregivers, informal carers and clients several recommendations can be made. These recommendations are made for managers and quality officers at nursing home organisations, for the caregivers of the nursing home organisations and for further research.

**Recommendations for nursing home organisations**

- Create support among your employees for the quality framework of nursing home care. The interviews showed that many of the caregivers had not heard of the quality framework for nursing home care, in which person-centred healthcare is one of the themes to improve.
- Flex workers are often necessary to deploy because of holidays or illnesses of the current staff and the shortage of personnel. It is recommended to develop a plan to facilitate the flex workers in providing person-centred healthcare. In this plan, the following topics are recommended to be included:
    - Let caregivers write down the essentials of every client in a concise way. Therefore, the client or their informal carers can be asked for verification of the information. The following things could be written down:
        - Practical things like whether the client has a hearing device, wears glasses or uses a denture.
        - The name of the client, and how the client wants to be approached
        - The disease profile of the client
    - Consider some extra time for facilitating flex workers in providing your clients with person-centred healthcare and support
- Develop a plan to keep the informal carers informed about the status of their relative. One of the informal carers stated it to be nice to be kept informed about the situation of their relative. When things in the disease profile deteriorate for example. It therefore is recommended to ask at the intake of a new client into the nursing home, whether their informal carer wants to receive this kind of updates.
- Do not cancel the transfer of shifts between caregivers. In the transfer, caregivers are able to tell their colleagues what happened in their shift, and tips can be given for the next shift.
- Every client has another disease profile, other characteristics and therefore other needs and wishes. The interviews implied that clients of somatic departments have other needs and wishes then clients of psychogeriatric departments. Therefore, it is recommended to be aware of these differences and to react upon these differences.

**Recommendations for caregivers**

- Discuss the characteristics, needs and wishes of each client with them or with their informal carer(s). File this information in a healthcare living plan and make that plan available for both the caregivers, the informal carer and the client. In that way, the client knows what he can expect from the caregivers, and the caregivers knows what to do to provide the care in a person-centred way.

The program 'Waardigheid en trots' and the knowledge platform 'Zorg voor beter' collected different methods for getting to learn your clients better. These methods are already used by nursing home organisations. These methods can be found at:
    - https://www.waardigheidentrots.nl/tools/publicatie-ken-je-client/
    - https://www.zorgvoorbeter.nl/persoonsgerichte-zorg/wens-client
- Though the quality framework states the healthcare living plan should be discussed at least twice a year, that should not stop clients, their informal carer(s) and caregivers from discussing it more often.
- Discuss on a regular base with the client and or his informal caregiver whether they are satisfied with the attention they, or their relatives, receive. You can ask them in which way it can be improved.
- Talk with your colleagues about person-centred healthcare and discuss:
    - How you can provide attention to all your clients, for both quiet and peak moments.
    - What you define by person-centred healthcare, and how you can provide it to all of your clients. Try to work together and help each other in doing so.
- Be aware of your own ideas and norms as a caregiver. What is ideal for you, does not have to be ideal for the client. Various informal carers of nursing home organisation A said that the nursing home in which their relative stays, is old and has really small bedrooms. But they also mention that their relative mostly sits downstairs in the living room, and because the nursing home is small, there also is a rather small group of caregivers. This results in the fact that clients do not have a lot of different faces for the care they receive, which is nice for clients who suffer from dementia.
- Dare to address an issue with your colleagues, but also dare to give each other compliments.

**Recommendations for further research**

This research is one step in discovering which facilitating and impeding factors are present in the implementation of person-centred healthcare in Dutch nursing homes. Further research is needed to validate whether the factors that were present in these nursing homes, are also present in other Dutch nursing home organisations. Therefore, the focus could be on the reliability of the questionnaires, and the inclusion of the questionnaire in a quantitative study on a bigger population of caregivers.

# 5 CONCLUSION

***Which facilitating or impeding factors are present during the implementation of person-centred healthcare in nursing homes, and how is person-centred healthcare perceived by clients?***

The facilitating factors that are present in all nursing homes are: professional obligation and personal benefits of the change. The facilitating factors that are absent in all nursing homes, are: communication about the change, having a program champion and involving network in the change. After the interviews, another factor that was absent in the nursing homes was added: having attention for patient characteristics. However, the results cannot imply that these factors are related to the implementation of person-centred healthcare.

The way person-centred healthcare is perceived by clients and informal carers in general is positive. Clients do mention downsides of the nursing homes: caregivers are often busy; some clients only have a shower once a week or have agreements about when to go to the toilet. This reliance on caregivers can be difficult, according to clients. Therefore, there can be made improvements on these kinds of agreements of the healthcare living plan.

The informal carers also are positive in general about the person-centred healthcare their relatives receive. Topics which can be improved by the nursing homes, according to the informal carers , are related to the attention their relative receives, the daily activities of the nursing home and how to make sure their relative has a nice day, and the lack of personal recognition of their relative in the healthcare living plan.

The results of this study led to recommendations for nursing home organisations and their caregivers on how to improve the implementation of person-centred healthcare.

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