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THE PERSPECTIVE OF RELATIVES ON THE OPTIMIZATION OF THE TRANSITION PROCESS TO A NURSING HOME

Master Thesis

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Abstract

Background information: According to a recent study, Dutch nursing homes do not meet the needs of elderly and relatives regarding the transition process to a nursing home. Marga Klompé therefore saw the importance of evaluating their transition process. Different aspects influence the experience of elderly and relatives on the transition process. However, literature research also did not yield results to what extent these aspects matter to elderly and relatives.

Study objective: Gain insight on how the transition process can be optimized from the perspective of relatives

Method: A digital survey was distributed among 520 relatives of clients from Marga Klompé. They answered questions about the term for the transition process, their satisfaction with the transition process and performed rank tasks about the importance of attributes on the optimization of the transition process. A combination of direct questioning, rating and ranking was used.

Results: Most respondents indicated that the term 'admission' evoked a feeling of sadness and the majority of the respondents chose "come to life" as a new term. The majority of the respondents were neutral or dissatisfied with the transition process. Involvement, familiarity with the building and nursing staff, the communication channel, a fixed contact person, use of language and completeness of information were the most important attributes. Educational level had influence on satisfaction and the importance of attributes.

Conclusion: This study revealed valuable information about the term, satisfaction and importance of attributes regarding the transition process. Due to methodological choices, caution should be applied when generalizing results. A review of the literature revealed an information gap on the subject, but, due to a changing perception on involving elderly in research, an increase of studies into this target group is expected.

Explanation of terms

The term “transition process” is used to describe the journey an elder takes when the elder is moving to a nursing home. The transition process starts with the decision whether the elderly should move to the nursing home, continuous with placement on the waiting list and choosing a nursing home, and ends with the actual move and the first days of the elderly living in the nursing home.

The term “client” applies to a person who receives care and is living in a nursing home. Residents of a nursing home are not necessarily ill, therefore the term “client” is most suitable. Also, this term fits the vision of Marga Klompé, the initiator of this study.

The term “relative” refers to the person who has (any kind of) relationship with the elder woman or man. The relative is involved in the (general) care for the elder such as the transition process.

Table of Contents

1. Introduction

In 2019, 115.394 elderly lived in a care or nursing home (1). This is 0.7% of the total Dutch population and 3.5% of the Dutch senior population (aged 65 years or older) (2). In 2016, 34.991 elderly were admitted to a nursing home (3). The number of people belonging to this age group is increasing, especially for those aged above 85 (4). It is prognosed that the number of required nursing home places will double in the next 20 years, consequently, the number of nursing home admissions will also increase per year (5).

The transition process to a nursing home can be a stressful and emotional experience and may lead to relocation stress syndrome (RSS) (6, 7). Symptoms may include anxiety, confusion, loneliness, depression, withdrawal, sleeping disorders, changed eating pattern, weight loss and gastro problems (6, 8). Of the elderly with RSS, 50 to 80% develop these symptoms which can last for up to a year (6). However, the diagnosis of RSS should be treated critically since it also could be an endogenous depression exacerbated by the relocation (9).

Relocation stress has been an approved nursing diagnosis for over two decades. Despite the recognition of the existence of the syndrome, guiding and supporting the elderly and family members during the process appears to be a challenge (9). The Dutch minister of health, welfare and sports received signals that the transition process to a nursing home does not seem to run smooth in practice and instructed Vilans (Dutch knowledge organization for long-term care) to conduct a research into the transition process (10). The results that were published in 2019 confirmed these signals; the transition processes to Dutch nursing homes do not meet the needs of elderly and their relatives (10). The long-term care assessment is bureaucratic and slow, there is little support for elderly from a frontline desk, poor information provision and a great deal of uncertainty about e.g. the financial consequences. Also, the social network of the elderly does not get enough opportunity to remain involved in the care for the elderly (10). As a result, the intention to provide person-centered care, as described in the quality framework for Dutch nursing homes, have been not met yet. Since all nursing homes are obliged to comply with the quality framework, the results of Vilans study were considered relevant for all Dutch care organizations involved in the elderly care sector (10, 11).

The quality framework was set up in 2017 and describes what elderly and their families can expect from care in nursing homes and instruct healthcare providers and healthcare organizations to improve the quality of care (11). The quality framework also introduced person-centered care. In person-centered care, the person is the starting point of care and it

states that care should be tailored to someone's specific needs, wishes and preferences. Healthcare professionals must approach the person as a human being instead of a patient (12). There is no single agreed definition for person-centered care because it is an evolving concept (13). The meaning of person-centered care depends on the circumstances and preferences of the individual receiving care and these even may change over time (13). Person-centered care leads to higher client satisfaction and better clinical outcomes (14, 15). There is a worldwide consensus that older people should be involved in the organization of care processes(16). Involvement is the key of person-centered care and helps identifying (unmet) healthcare needs. But there is limited evidence on how to do this and in practice and elderly with multimorbidity are still little involved in decision-making (15).

2. Theoretical framework

According to the elderly and their relatives, various aspects affect the experience on the transition process to a nursing home(7, 14, 16-29). These aspects were identified during a mini-review and described in this theoretical framework. For the mini-review, the suggestions made by Griffiths were followed (30). Details of the mini review can be found in appendix 1. From this mini-review the following aspects will be discussed in this theoretical framework:

Involvement

Ownership and involvement are essential for a healthy transition process. The degree of involvement of elderly and their relatives influences the overall experience of the transition process (7, 20). Elderly who are involved in the decision process of the transition look back more positively, feel better afterwards and are better able to psychologically adjust to the new situation (26, 28). Elderly and relatives emphasized they want to be involved in the decision whether a nursing home admission is necessary (17, 18, 24). Some other aspects in the mini-review indicated that the target group wanted to have a say in which nursing home the elderly is placed (24, 25). Furthermore, they want to be involved in the planning of the transition process, for example, the moment of moving or meeting fellow residents (16, 18, 19). It was also mentioned that elderly and relatives want to be involved in formulating the care goals (16). Finally, elderly and relatives want to have the opportunity to express their wishes and needs and also want to experience that these wishes are respected by professionals (14, 16, 26).

These findings are important because when elderly and their relatives have no influence on the transition process, they feel unprepared and powerless. This creates a reduction in psychological wellbeing due to feelings of fear, insecurity and dissatisfaction (16, 17, 22, 24). Also, it can lead to the feeling of a forced transition which is associated with anger, sadness and depression (7, 26).

Elderly experience unequal power between the care provider and themselves. As a result, they are reluctant to tell what their preferences are and wait until they are asked for their preferences (19). Contrary to what might be assumed, elderly and their relatives do want to be involved and also want to make the effort to bear responsibility (19, 28). But in practice, elderly often experience low involvement during the transition process. This might be caused by the different interpretations of involvement and little evidence in which way older people should be involved in decision making (15). Low involvement has its effects on the long term. For example, elderly with low perceived control and satisfaction report greater loneliness than

elderly that report high perceived control and satisfaction (29). Conversely, patients with perceived control and greater fulfilled preferences were less lonely and reported higher life satisfaction (29).

Involvement of relatives is crucial for a smooth transition process. Their support, for example, is considered important for a healthy transition (20). Also, the presence of relatives gives a sense of safety to the elderly (16). Further, the position of elderly is strengthened by the presence and support of relatives and makes it easier for elderly to influence the transition process and share their preferences (19). In addition, relatives provide important or even crucial information (e.g. life story or medical history) about the elderly (19, 25). From previous research, relatives indicate that they often feel involved when deciding whether their loved one should move to a nursing home (21). However, after the decision, they feel left out of the transition process, which results in an overall negative experience during the transition process (21).

Support

The decision whether an elder should move into a nursing home is complex and stressful (28). Also the move itself is a stressful period for elderly and their relatives (7). Elderly and their relatives want to feel that other people are aware of what the impact of the transition is on their life (28). They want to be heard and feel compassion (7, 28). It is important for caregivers to pay attention to the emotional stress because the quality of care improves when health care professionals listen to the elderly's story and recognize the emotional troubles (26). When elderly and relatives can express their feelings and receive support from competent caregivers, they give a higher quality score (26). Said felling of support, reduces the stress level which also has a positive effect on their physical and mental well-being (14, 26).

It is specifically stated that, beside the elderly, also relatives need emotional support from a competent health care professional. It is important for caregivers to recognize the emotional burden of relatives because it makes the relatives feel more comfortable (25). Relatives want caregivers to consider them as part of the elderly's life (21, 25). They especially want support during decision-making the difficult time when they need to decide whether their loved one should move to a nursing home and during the transition period because making said choice takes its toll (23). Relatives also need assistance in understanding the elderly's mood and behavior (7). One study described that relatives, especially spouses, do not feel supported and prepared enough for emotional distress in the transitional period (21).

In addition to emotional preparation for the transition to a nursing home, elderly and relatives also want practical preparation and help for the move. They want to know what must be arranged and what not to forget regarding the relocation. A relocation checklist is given as an example of a helpful tool during the move (16, 20).

Communication and information

A transition into a nursing home is a complex process in which good mutual communication is important (14). According to elderly and relatives, good communication requires clear language that is understandable for them. In addition, health care professionals should be able to switch between sending information and receiving information, in order to create the opportunity for elderly and relatives to ask or give a clarification (14). Thus, elderly and relatives indicate that they find it important that communication takes place. Although this sounds obvious, it was mentioned because it does not always seem to happen in practice (18). Due to this lack of information or communication the actual move to the nursing home still comes as some sort of surprise (25). In communication, elderly and relatives find it important through which channel the communication runs. No direct preference is expressed, but they do indicate that the type of channel influences their experience about the communication (19). Also, the degree of communication between health care professionals, relatives and elderly is important for the overall experience (14, 18). Furthermore, the moment when the communication takes place and the understandability of the language, were mentioned as an influencing factors (16, 19). Elderly and relatives indicate that they prefer a systematic exchange of information (18). They also like to have an easily accessible contact person who they can approach with questions (16, 19).

In addition to communication, information plays an important role because elderly and their relatives described the transition of care as successful when they feel that they received correct, relevant and complete information (16). The use of understandable language is important for elderly and relatives to be able to properly understand and process the information obtained (16, 19). The provided information should prepare elderly and relatives on what they can expect from the transition process and the nursing home (18). In practice, given information is often too general and does not apply to the specific situation that the elderly is in (25). For elderly and relatives it is important to receive relevant information because this helps adjusting expectations which is part of a healthy transition process (21). Elderly and relatives want access to information about their transition process and the nursing home so they can participate and anticipate more actively (28).

One study indicates that the elderly's relatives often feel that they have received too little information about the nursing home before the move (21). Elderly and relatives would like to know to whom they can turn if they want information about the transition process (7, 19, 25). Elderly would like to know what information has been shared between care providers because not knowing this can lead to uncertainty and confusion (19). One study revealed that elderly would like to know how moving will work in practice and what possessions they are allowed to take with them (24).

Continuity of care

When the continuity and coordination of care are not properly guaranteed, the elderly and family members feel more insecure and stressed (14, 16, 18). Therefore, elderly and their loved ones want clarity about who is primarily responsible for the transition process and the transfer (14, 16, 18). In addition, the extent to which care transfers seamlessly from one care provider to another and how different parties work together is important (14, 16, 21).

Possessions

Elderly indicate that they consider it important to be able to take possessions with them and that they would like to receive information about this beforehand (24). Bringing possessions to the new living environment can contribute in creating a feeling of home which helps the elderly better adapt to the new situation (7, 24).

Familiarity

For most elderly and relatives, nursing homes are a strange and unknown environment (28). Therefore, there is a great need from the elderly and relatives to familiarize with the nursing home and environment before the admission (28). Familiarity with the nursing home, the environment, nurses and fellow residents gives a feeling of security, good preparation and results in a better experienced transition process (27). Not knowing the nursing home is stressful and increases the sense of loss of control in elderly and relatives (25). Elderly and relatives prefer the nursing home to be located in a known place or community (27). Before admission, elderly and their relatives are happy to know what the nursing home and the room in which the elderly will stay looks like. They also feel the need to meet the caregivers before the actual admission so they can share their needs with them (28). Additionally, elderly and relatives aim to build a trusting relationship between the care staff, the elder and their loved ones (27).By seeing the nursing home and speaking to nurses and residents before the move, negative expectations and prejudices can be reduced or removed (27).

Term used for the process

One study mentioned the importance of the term used about the transition process. Some of the used terms evoke negative expectations and associations with living in a nursing home (16). A given example is that that an elderly will not be ‘placed’ in a nursing home, but is going to live in a nursing home. In addition to literature, the working group “person-centered care” from Marga Klompé has indicated that they would like to receive information whether the term "admission process” is appropriate and client-oriented. The working group “person-centered care” expects that elderly and relatives might prefer a different term to be used because a different term may yield fewer negative- or even more positive associations with the nursing home.

3. Study objectives

Based on the results of Vilans' research and own findings, Marga Klompé acknowledge the importance of evaluating and improving their own transition process. The aim of Marga Klompé is to optimize their transition process from a cliental perspective. Since there is no existing definition for an optimal transition process, the following definition was formulated with the involvement of expert groups from Marga Klompé; *"For Marga Klompé, the transition process is considered optimal when clients and/or relatives indicate that the transition process meets their wishes and needs, while at the same time, employees of Marga Klompé still perform the tasks that are necessary for the transition of a new client and the quality of care can remain at a good level from this perspective."*

As can be seen from the theoretical framework, according to elderly and their relatives, several aspects influence the experience of the transition process. However, the literature from this mini-review did not provide information on the importance of these aspects. Additional literature research also did not yield results to what extent these aspects matter to elderly and relatives. Since Marga Klompé has to deal with restrictions in time, financial resources and manpower, information on the importance of the aspects is needed because it is unrealistic to implement all aspects into the transition process.

This study aimed to gain insight on how the transition process can be optimized from the perspective of relatives. Three sub-goals were created to find this out. The first objective is to gain insight on the emotions and needs related to the term for the process. The second objective is to obtain information about the satisfaction of relatives with the current transition process. The third objective is to determine the importance of attributes regarding the transition process from the perspective of relatives. Four research questions arose from these three objectives, which were formulated as follows:

1. What emotion does the current term "admission to a nursing home" evoke in relatives?
2. Which term do relatives consider most appropriate to describe the transition from home to the nursing home?
3. How did relatives experience the transition process from Marga Klompé?
4. Which attributes are important from the perspective of relatives in optimizing the transition process to the nursing home?

4. Methods

This study had a cross-sectional design in which 520 relatives of clients from Marga Klompé's were invited for a one-off digital survey about the transition process to the nursing home.

4.1 Selection of attributes and levels

The following eight attributes were identified through the mini-review; involvement, emotional support, practical support, familiarity, communication, information, continuity and possessions. These attributes were assessed by three expert groups from Marga Klompé. The first expert group consisted of a manager of different care locations and a quality and safety advisor, both were also are members of the workgroup “person-centered care”. The second expert group consisted of three employees from the frontline desk. The last expert group were three nurses from a care department who are experienced with admissions of new clients. Each expert group was interviewed separately. All experts considered the identified attributes recognizable and agreed that these attributes play a role in the experience of the transition process. No attributes were removed after consulting expert groups. However, suggestions were made for changing the Dutch terms for the attributes “involvement” and “familiarity”. These suggestions were applied in the survey text. All experts indicated that they missed an attribute that addressed the extent to which clients and relatives felt that Marga Klompé really knew them as a person when entering the nursing home. Also, they indicated that they missed an attribute that addressed the extent to which clients could continue their way of life, as they were used to, in the nursing home. Both of the mentioned attributes were added to the list of attributes as “they know me” and “continue life”. Eventually, ten attributes were identified. Table 1 gives insight in the ten attributes and their definitions.

Marga Klompé desired additional information with regard to communication and information, because in practice it is a challenge to meet the needs of a new client and his relatives regarding these attributes. Furthermore, Marga Klompé desired additional information about familiarity. With information about this attribute, Marga Klompé can assess whether an already ongoing pilot, with home visits by nurses, meets the needs of new clients and relatives. The attributes “communication”, “information” and “familiarity” consisted of 6 levels and were described in table 2.

Table 1: the ten attributes and their definitions

Attribute	***Definition***
Involvement	The extent to which elderly and/or relatives feel that their wishes with regard to the transition process were being respected, the extent to which they play a role in decision-making and the degree in which they feel in control about the organizational side of the transition process.
Emotional support	The extent to which elderly and/or relatives feel emotionally prepared and supported by a competent health care professional during the transition process
Practical support	The extent to which elderly and/or their relatives feel prepared and know what they should arrange for the transition to the nursing home on practical level
Familiarity	The extent to which the elderly and / or relatives have been able to become familiar with the nursing home as a building, the environment of the nursing home, the health care professionals and fellow residents.
Communication	The extent and the way in which communication takes place between elderly, relatives and involved (health care) professionals.
Information	The information provided to the elderly and / or relatives contains understandable language, is complete, clear, relevant and helps in the preparation for the move to the nursing home.
Continuity	The extent to which the elderly and / or family members feel that the care is seamlessly transferred from one care provider to another, whereby these different parties work together
Possessions	The possibility and extent to which elderly are allowed to bring their belongings to the nursing home
Know the person	The extent to which clients and relatives felt that the organization really knew them as a person when entering the nursing home
Continue life	The extent to which clients and relatives felt that the was client able to continue the activities that give a meaning to the life of the client when they are admitted to a nursing home.

Table 2: Levels for the attributes familiarity, communication and information

Attribute	*Level*
Familiarity	Familiarity with the nursing home
	Familiarity with the environment
	Familiarity with the nursing staff
	Familiarity with the paramedics
	Familiarity with the physician
	Familiarity with residents
Communication	Channel
	Frequency of contact
	Timing of the contact
	Understandable language
	Question opportunity
	Contact person
Information	Understandable language
	Completeness
	Channel
	Amount of information
	Relevance of the moment
	Relevance of the situation

4.2 Survey design

For the data collection, a digital survey was developed in Qualtrics XM and distributed among the study group by email. The survey consisted of five sections. In the first section, the respondent was asked for his age, gender and whether he was present at the transition process of the client. If so, the respondent was offered section 2, 3, 4 and 5 of the survey. If not, the respondent was not able to indicate how he experienced the current transition process and was therefore referred to section 3.

Section 2 contained eleven questions about the respondent's experience of the transition process. The 3th section contained two questions about the term used for the transition process. Section 4 contained four ranking tasks about respondents' preferences regarding the transition process. The last section contained eight questions about the respondent's background information.

The chance on socially desirable answers was minimized by anonymizing the survey and giving the respondents the opportunity to complete the survey alone, without the influence of others, at their own chosen moment in their own chosen environment (31).

For answering the research questions a combination of direct questioning, rating and full ranking was used. In the paragraphs below, for every research question, the used method is explained in more detail.

4.2.1 Emotion evoked by the term

Through direct questioning, the respondents were asked what emotion the term “admission to the nursing home” evoked in them. The respondents were able to choose from eight different emotions; love, fear, joy, anger, grief, surprised, shame and disgust. Choosing multiple emotions was possible. Furthermore, this question had a “blank space” so that respondents were able to enter emotions they were missing in the provided answers.

4.2.2 Term for the transition to the nursing home

Direct questioning was also used to find out which term respondents would choose for the transition process. A list of five potential terms was compiled by the expert groups of Marga Klompé and consisted of; “admission process”, “moving away”, “come to live”, “moving in” and “bring home”. Respondents had to choose one of the provided terms or could use the “blank space” so they could enter a suggestion for the term invented by themselves.

4.2.3 Satisfaction current transition process

A rating technique with a 5-point likert scale was used to collect information on how the current transition process was experienced by the respondents(32-34). The likert scale is a psychometric scale which can be used for transforming subjective answers into numerical values so that they are better interpretable and can be used for statistical analyses(35-37). The likert scale is widely used and suitable for evaluating the respondents' experience of the transition process. Rating has a low cognitive burden on respondents and also the number of attributes can be performed within this method(38). For rating, the average number of attributes used is 8 and it is recommended that no more than 12 attributes should be used in combination with this method.(39, 40)

To measure the satisfaction, respondents assigned a score to the overall experience and scored every attribute separately. Before answering the questions, respondents received the definitions of the attributes and an explanation of what the different scores meant. A score of 1 was considered very dissatisfied, a score of 2 was considered dissatisfied, a score of 3 was considered as neutral (neither dissatisfied nor satisfied), a score of 4 was considered satisfied and a score of 5 was considered very satisfied.

4.2.4 Importance of attributes

Since measuring the importance of the attributes concerned a preference sensitive decision, methods for Multiple Criteria Decision Analyses (MCDA) were considered (38, 41). Three requirements played an important role when selecting the method. First, the number of attributes were taken into account when choosing the methods, because some MCDA methods have a limited number of criteria that can performed with the method (39, 42). Second, it was a high priority that the burden on the respondents remained as low as possible (39, 42), Third, the method must be appropriate for revealing which outcomes are important for respondents (39, 42).

Full ranking was selected to measure which attributes relatives consider important for optimizing the transition process (43-45). Ranking is a commonly used method to support decision-making in the clinical setting and has a low cognitive burden on respondents (38). It is suitable for this study since it is appropriate for identifying what respondents consider important regarding the attributes of the transition process. It mimics the trade-offs that Marga Klompé is forced to make in practice. The number of attributes can be performed within this method. The average number of attributes is 8 and it is recommended that at a maximum 12 attributes should be used in combination with these MCDA methods (39, 40).

In the first ranking task, the respondents placed ten attributes, as shown in table 1, in an order from most important to least important. This was followed by three more ranking tasks that focused on communication, information and familiarity, as shown in table 2.

4.2.5 Background information

The following background information was asked from the respondents; age in years (<20 years, 20-39, 40-59, 60-79, 80-99, >100), gender (male, female or other), highest completed educational level (primary school, VMBO, HAVO, VWO, MBO, HBO, WO), ethnic background (Dutch migration background, western migration background, non-western migration background), relationship with the client (spouse, son, daughter, son in law, daughter in law, grandchild or other), the municipality in which the client is registered (Aalten, Berkelland, Oost Gelre, Lochem, Winterswijk), type of care needs assessment (zzp5, zzp6, zzp7, zzp8, zzp9 or “I don’t know”), from which place the client was admitted to the nursing home (home with a regular route, home through crisis, hospital, rehabilitation unit, primary care unit (ELV), observation unit , transferred from another nursing home or other) and how many years the client has lived in a nursing home of Marga Klompé (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, <10).

4.3 Study population and recruitment

This study was conducted among the relatives of clients from Marga Klompé. Only relatives of clients that were admitted with a zzp5, zzp6, zzp7, zzp8 or zzp9 with intramural treatment were included in the study.

This study population was chosen for several reasons. Marga Klompé had questions related to their specific situation and relatives were considered a representative group. The study population was easily accessible through Marga Klompé and it was assumed that this target group had some digital skills so that they were able to complete a digital survey.

Relatives of clients who were admitted with a zzp1, zzp2, zzp3 or zzp4 were excluded from the study. Also, relatives of clients who were admitted with a zzp5, zzp6, zzp7, zzp8, zzp9 without intramural treatment were excluded from the study. In the aforementioned groups, the general practitioner remains the head practitioner and plays a major role in the organization of the transition to a nursing home. In these cases, Marga Klompé has little influence on the transition process, which was the reason to exclude this group from this study.

Before the survey was distributed among the study group, a pilot test was performed. The first pilot group consisted of nurses, employees from the frontline desk and family and friends from the researcher. The second pilot group consisted people who are trained in communication and organize a large part of the communication within Marga Klompé. Through their work within Marga Klompé, they have a good understanding which type of language and text structure suits the study population best. Feedback was requested from both pilot groups, focusing on the readability, comprehensibility, length and difficulty of the survey. After adjusting the survey based on the feedback, the survey was finalized and sent to the relatives. The purpose of the pilot test was to develop the survey in such a way that the relatives were motivated to complete the survey, resulting in a higher response rate (31).

4.4 Sample size

No power calculations were available for full ranking, rating and direct questioning. Therefore, comparable studies were used to determine the sample size. Studies with a full ranking method had at least a sample size of n=10 and at the most a sample size of n=447 (43-46). Studies with a rating method had at least a sample size of n=35 and at the most a sample size of n=244 (32-34, 46). However, these studies did not substantiate their sample size. One study claimed they used calculations to determine the sample size, but they did not indicate which calculations they used (33). Another study indicated that, due to the absence of power calculations, they opted for a pragmatic approach and chose a sample size that seemed

feasible to them within the set time frame(47). Other studies did not substantiate the sample size, but also seemed to adjust the sample size based on feasibility (45, 48).

Because feasibility was a determining factor in previous studies for the sample size, this was also considered when determining the sample size for this study. As can be seen in table 1, 529 relatives of clients from Marga Klompé, complied with the inclusion criteria for this study. According to Shih (49), a response rate of 33% could be expected. Which means that, approaching all 529 relatives, may result in 175 respondents.

The size of the study sample influences the internal and external validity of the study (50). A sample size of 175 is considered sufficient to ensure internal validity since it is expected that the variation of respondent characteristics among the relatives is limited. Whether 175 respondents would be sufficient for external validity depended on the composition and diversity within the group of relatives. Because no background information about the study group was known, it was difficult to determine this in advance. The chance on limited external validity was accepted since generalizability beyond Marga Klompé was not an objective of the study and therefore less important.

Table 3: Number of clients per type of care indication

Type of care indication	Number of clients
zzp5 with treatment	322
zzp6 with treatment	158
zzp7 with treatment	37
zzp8 with treatment	4
zzp9 with treatment	8
Total	529

At the time the survey is sent to the relatives, the number may deviate due to the death and moving of clients.

4.5 Statistical analysis

The (statistical) analysis was performed by using SPSS statistics (version 27) and Microsoft Excel. The level of significance was set at 0.05.

First, statistical analyses was performed on the completion of the survey to determine whether this was influenced by age or gender. Through a crosstab, the variables "gender" and "age" were set against "completion of the survey". Potential differences in percentages were analyzed visually and tested on significance using Chi-square.

After the analyses on the completion of the survey, the data from the unfinished surveys was removed in the SPSS data file. Finished surveys that contained empty cells were still used in the analysis. It was decided to keep this data in the analysis for two reasons. First, the values were not directly dependent on each other, so an empty question did not mean that another filled question had less or no informative value. Second, removing the respondents with empty values would have left too few cases for the analyses.

To gain insight into the study population, the background information about the respondents was analyzed through descriptive statistics in SPSS. The frequencies and percentages were calculated. The original variables of age, relation with client, chronic care indication and living years resulted in small sample sizes (n=<10) in the subgroups. Therefore, these variables were recoded into new variables where the subgroups were not smaller than n=10. An exception was made with regard to sample sizes of the subgroups of different regions. Region Berkelland had a sample size of 4, but was not merged with another region since this would give a distorted view of the regions. Educational level was recoded into a new variable to make the data comparable with the educational classification systems of the data supplied by the Dutch government. An overview of the old and new variables can be found in Appendix 2.

The frequencies of the evoked emotions by the term “admission” and the potential new term were determined using descriptive statistics in SPSS. The information that respondents typed in the blank space was summarized and described textually.

The analyses on the satisfaction with the transition process started with calculating the Cronbach’s Alpha, which gave insight into the homogeneity of the answers to the 11 questions regarding the satisfaction with the transition process. Subsequently, the answers to the eleven questions related to satisfaction were used to create a sum score for the total group and the subgroups gender, age, education, relationship, care indication, living years, route and region. The lowest possible sum score was 11, the highest possible sum score was 55. The sum score of the total group was spread over a range of 15 to 55, which was difficult to interpret. For this reason, a new variable was made in which the sum scores were transformed into the following five categories; extremely dissatisfied (sum score 11-21), dissatisfied (sum score 22-32), neutral (sum score 33-43), satisfied (sum score 44-54) and extremely satisfied (sum score 55).

Statistical analyses was performed to determine the effect of gender, age, education, relationship, care indication, living years, route and region on the satisfaction. Because of the small sample sizes (n=<25) within some of the subgroups, the Mann-Whitney U (for 2

variables) and Kruskall-Wallis (for more than 2 variables) were used (51). Based on the standard deviation and variance additional visual analysis was performed on the respondents who were very dissatisfied, dissatisfied and very satisfied since they were considered as outliers.

In addition to the analyses of the sum score, the 10 attributes were analyzed separately. For each attribute, descriptive statistics was used to calculate in frequency and percentages for each answer category for each question (table 5). The focus was on the low-performing attributes. An attribute was considered low-performing when 10% of the respondents indicated that they were very dissatisfied and / or dissatisfied concerning the attribute.

To determine the importance of the attributes, the frequency was calculated of which an attribute or level was ranked first place. Because an effect of gender, age and education level on the importance of attributes was expected, subgroup analysis was performed (52, 53). The frequencies and percentages per attribute were derived from SPSS trough descriptive statistics and crosstabs. The results from the total group and subgroup educational level were transformed into basic bar charts. The results from the subgroups age and gender were transformed into tornado charts. Only visual analyses was performed on the charts.

4.6 Ethical considerations

During this study, relatives were asked if they want to fill out a survey once. Based on informed consent, the relatives were free to decide whether they wanted to participate in the study. The relatives could stop at any time during the completion of the survey without any consequences. When developing the survey, the burden of the target group was considered and was kept as low as possible. Because this study involved human subjects, it was assessed by the BMS-Ethics committee of the university of Twente to ensure the study is ethically responsible.

5. Results

5.1 Respondent characteristics

The survey was sent to 520 respondents on December 16, 2020 and the survey was closed on January 8, 2021. During that time, 265 respondents agreed to participation in the study. Of these respondents, 190 (72%) completed the survey. Statistical testing showed no significant effect of gender (p=0.226) and age (p=0.167) on the completion of the survey. Table 4 gives insight in the respondent characteristics.

Table 4: Respondent characteristics

Respondent characteristics		***n (%)***
Gender (n=190)	Male	68 (35.8%)
	Female	122 (64.2%)
Age (n=190)	<60	85 (44.7%)
	60 years or older	105 (55.3%)
Educational level (n=188)	Low	32 (17.0%)
	Middle	92 (48.9%)
	High	64 (34.0%)
Ethnic background (n=189)	Dutch	188 (98.9%)
	Western migration	0 (0%)
	Non-western migration	1 (0.5%)
Role in admission process (n=189)	Yes	176 (92.6%)
	No	13 (6.8%)
Relationship with client (n=189)	Spouse	22 (11.6%)
	Son	42 (22.0%)
	Daughter	87 (46.0%)
	Son or daughter in law	11 (5.8%)
	Other	27 (14.3%)
Region of admission (n=189)	Aalten	28 (14.7%)
	Berkelland	4 (2.1%)
	Lochem	33 (17.4%)
	Oost Gelre	51 (26.8%)
	Winterswijk	73 (38.4%)

Chronic care indication (n=187)	Psychogeriatric indication	54 (28,9%)
	Somatic indication	40 (21.4%)
	Unknown	93 (49.7%)
Route from admission (n=189)	From home regular	60 (31.6%)
	From home crisis	27 (14.2%)
	Hospital	34 (17.9%)
	Rehabilitation	41 (21.6%)
	Transfer	26 (13.7%)
	Unknown	1 (0.5%)
Living years (n=184)	1 year	80 (42.1%)
	2 years	32 (16.8%)
	3 years	24 (12.6%)
	4 years	17 (8.9%)
	5 years	10 (5.3%)
	More than 5 years	21 (11.1%)

The number of respondents in the total group differs per demographic characteristic because the participants were not obliged to answer a survey question

5.2 Term for the transition process

As can be seen from figure 1, most respondents indicated that the term 'admission' evoked a feeling of sadness. 21% of the respondents used the free space and entered another emotion such as; relieve, reassurance, disappointment, insecurity and impotence. The blank space was also used by the respondents to give an explanation on their feelings. Some respondents looked at it from, as they called it themselves, a realistic perspective and indicate that the admission was a necessity. Some respondents indicated that the term "admission" feels loaded because they felt "no way back" and admission to the nursing home is considered as a "final destination". On the other hand, there were also respondents who thought that the term makes the admission process appear as something temporary, while this is not the case. 63% of the respondents selected only one emotion and 37% selected more than one emotion, own proposal included.

As can be seen in figure 2, the majority of the respondents chose "come to live" as the potential new term for the transition process. 6% of the respondents had an own proposal for the term or used the open space for a comment. One person indicated that he was not able to make a choice because he felt that none of the terms covered the meaning of the process properly. But he also said that he found it difficult to come up with a good alternative himself. Two respondents indicated that the term was not important, because the transition process will be

an emotional and difficult event anyway; it does not have to appear better than it is. They considered it more important how they are treated during the transition process. Six respondents indicated that they would like to see a term such as “moving” or “coming to live”, but this term must also include a description of day and night guidance or care which suits the elderly and offers safety. One respondent felt it depends on the form of admission which term is most appropriate.

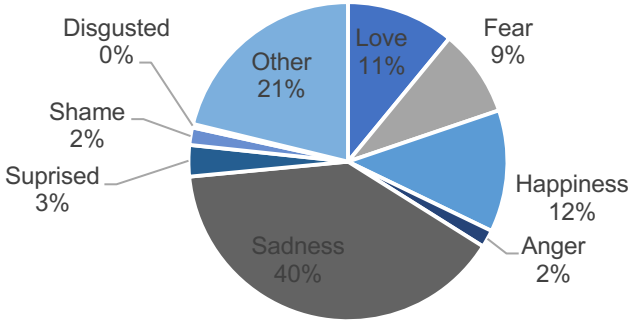

Figure 1: emotion evoked by the term "admission"

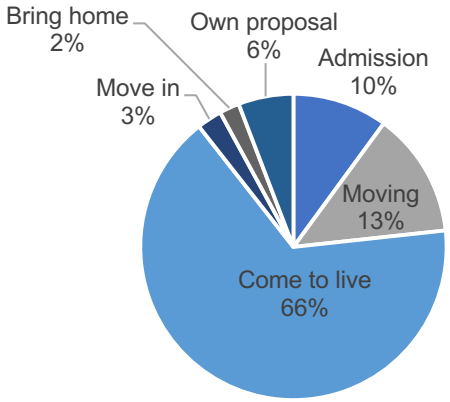

Figure 2: Term chosen for the transition process

5.3 Satisfaction with the transition process

The Cronbach’s Alpha (0.936) indicated a high homogeneity in the answers of the respondents, from which it was concluded that the respondents were consistent in the score they gave about the transition process. As can be seen in figure 3, most respondents were neither dissatisfied nor satisfied. A third of the respondents was satisfied. 10% of the respondents was either (extremely) dissatisfied or extremely satisfied.

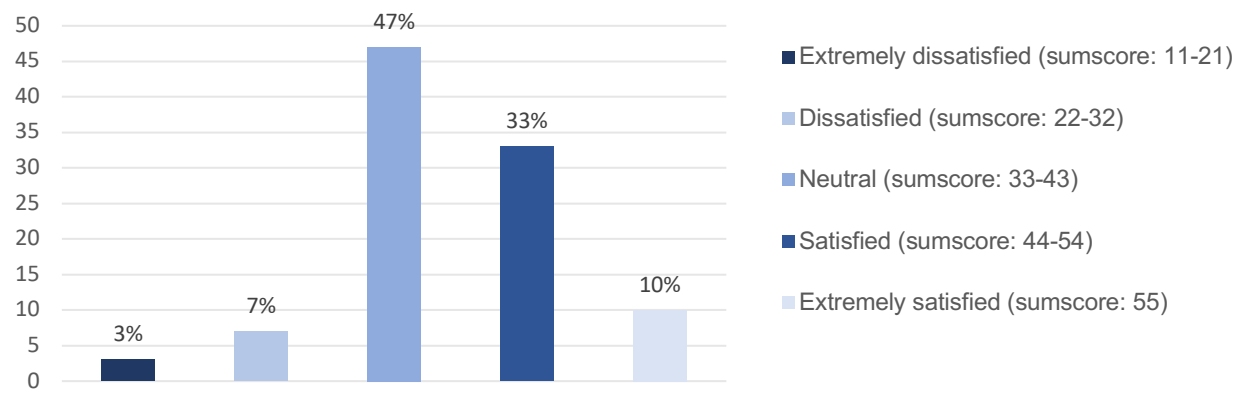

Figure 3: Overall satisfaction with the current transition process (%)

When analyzing the attributes separately, “emotional support”, “practical support”, “familiarity” and “they know me” were low-performing. Respondents were most satisfied with the attribute “possessions”. More detailed information about the satisfaction per attribute can be found in table 5.

Table 5: Satisfaction per attribute

Attribute	Extremely dissatisfied	Dissatisfied	Neutral	Satisfied	Extremely satisfied
Overall satisfaction	3 (2%)	6 (4%)	3 (17%)	94 (53%)	43 (24%)
Involvement	3 (2%)	8 (5%)	33 (19%)	94 (53%)	37 (21%)
Emotional support	10 (6%)	14 (8%)	62 (35%)	58 (33%)	31 (18%)
Practical support	7 (4%)	18 (10%)	49 (28%)	67 (38%)	36 (20%)
Familiarity	15 (9%)	17 (10%)	43 (24%)	65 (37%)	35 (20%)
Communication	4 (3%)	9 (5%)	43 (24%)	72 (41%)	48 (27%)
Information	6 (3%)	6 (3%)	44 (25%)	74 (43%)	43 (25%)
Possessions	4 (2%)	5 (3%)	37 (21%)	75 (43%)	55 (31%)
Continuity	4 (2%)	11 (6%)	43 (24%)	73 (41%)	45 (26%)
Continue life	7 (4%)	10 (6%)	51 (29%)	63 (36%)	44 (25%)
They know me	7 (4%)	13 (7%)	41 (23%)	70 (40%)	46 (26%)

5.4 Importance of the attributes and levels

In the transition process, involvement and familiarity were considered most important by respondents (figure 4). Regarding familiarity, familiarity with the nursing home and familiarity with the nursing staff were most important (figure 5). With regard to communication, respondents found it most important to have a permanent contact person and the type of channel through which the communication takes place (figure 6). For the provision of information, completeness of information came forward as most important (figure 7).

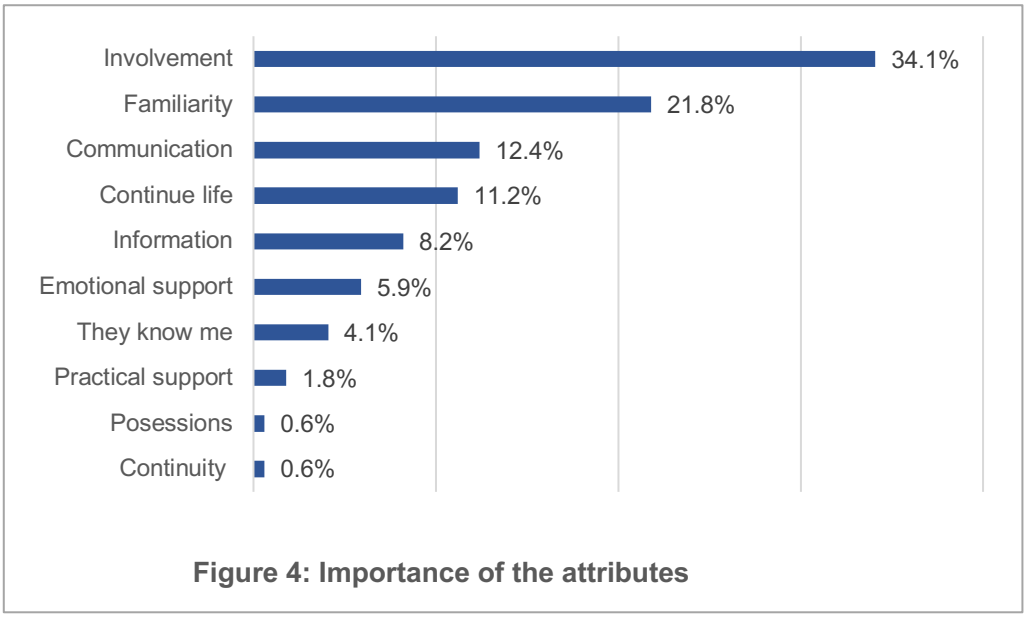

Figure 4: Importance of the attributes

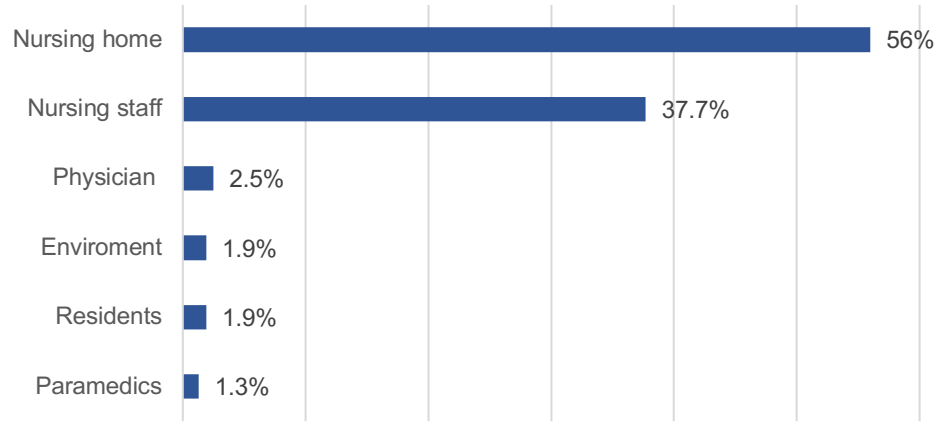

Figure 5: Importance of the levels of familiarity

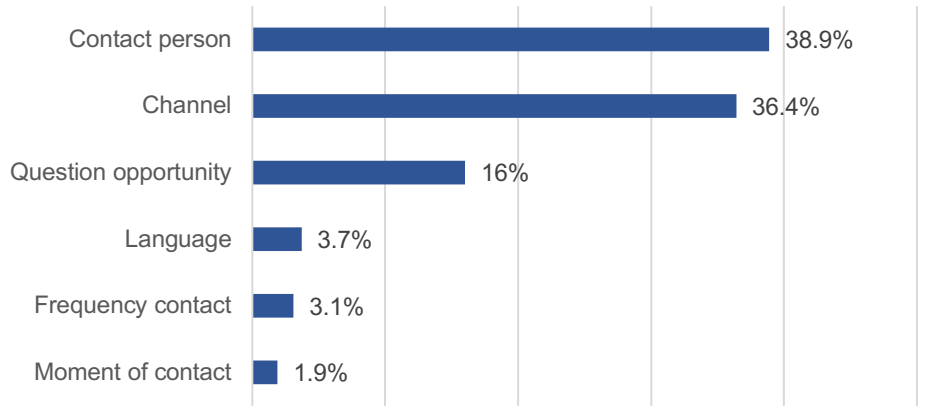

Figure 6: Importance of the levels of communication

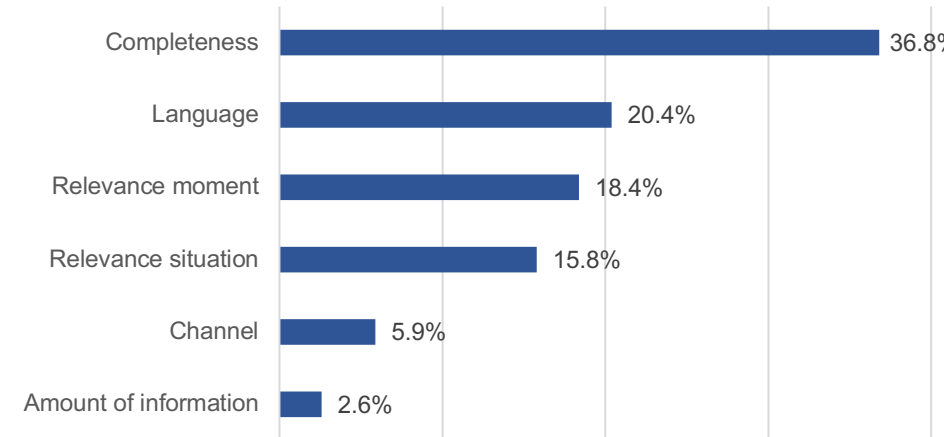

Figure 7: Importance of the levels of information

5.5 Other findings

5.5.1 Subgroup analyses on satisfaction

After statistical testing on all subgroups, only educational level had a significant effect on the satisfaction with the transition process (p-value = 0.001). Respondents with a high educational level were more often dissatisfied compared to respondents with a low and middle educational level. Respondents with a low educational level more often were extremely satisfied compared to middle and high educated respondents.

The size of the standard deviation (8.37) and the variance (69.98) of the sum score showed a wide spread in de sum score which gave reason to perform visual analyses into the outliers (extremely dissatisfied, dissatisfied or extremely satisfied). This showed that spouses and daughters were more often unsatisfied compared to sons, sons/daughters in law or other relatives. In the region Aalten, there were more respondents who indicated that they were unsatisfied compared to the respondents in one of the other four regions. Visual analyses also showed that male were more often extremely satisfied compared to females. Respondents with age 60 and older were more often extremely satisfied than respondents with an age below 60. Respondents who experienced the transition process 4 years ago or more than 5 years ago were more often dissatisfied but also more often extremely satisfied compared to respondents who experienced the transition process 1 year ago. No noticeable differences were observed visually in the group's "indication" and "route to nursing home". Detailed information regarding the subgroup analyses of the sum score can be found in table 6.

5.5.2 Subgroup analyses on the importance of attributes

In this subgroup analysis, only the subgroups discussed where the importance of attributes and levels differed from that of the total group. Appendix 3 contains all graphs belonging to the subgroups, that not mentioned in this section.

Regarding the levels of information, for respondents younger than 60, completeness of information and language use were equally important and placed first. Relevance of the moment was third most important, followed by relevance of the situation (figure 8). For respondents of 60 years and older, completeness was most important, followed by relevance of the moment. Language use and relevance of the situation came on a third and fourth place.

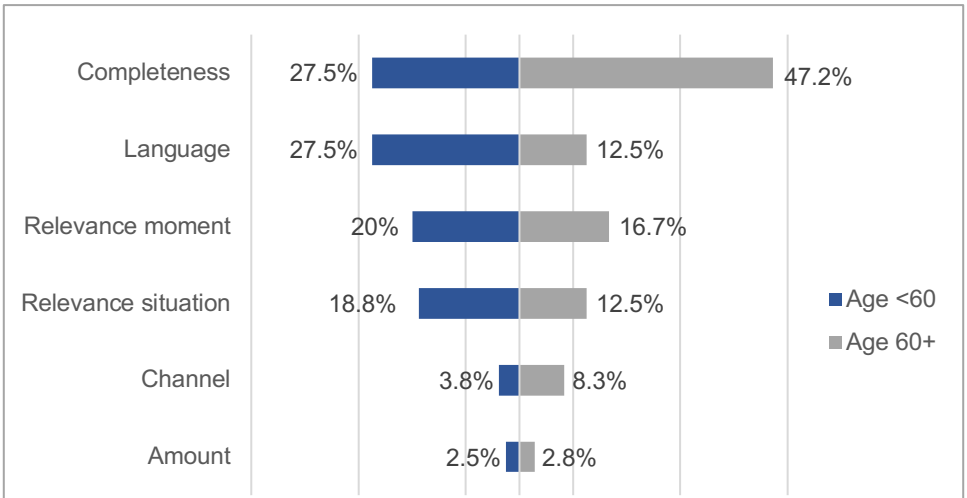

Figure 8: Importance levels information by age

For the communication, male indicated the channel as most important, followed by a fixed contact person. Female indicated a fixed contact person as most important, followed by the channel (figure 9).

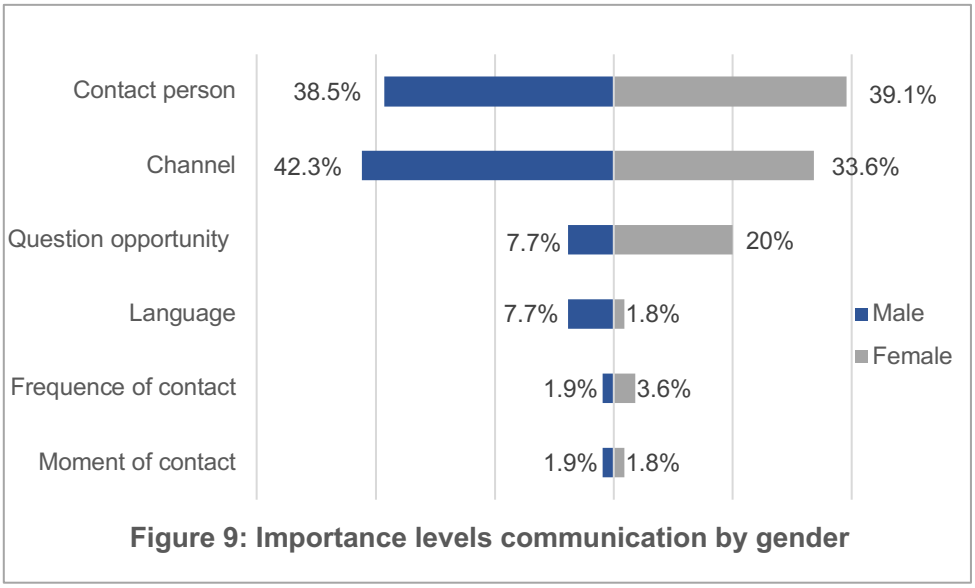

Figure 9: Importance levels communication by gender

With regard to familiarity, men find it most important to get to know the nursing staff. They placed familiarity with the building on a second place. Women indicated that knowing the building is most important to them, followed by getting to know the nursing staff (figure 10).

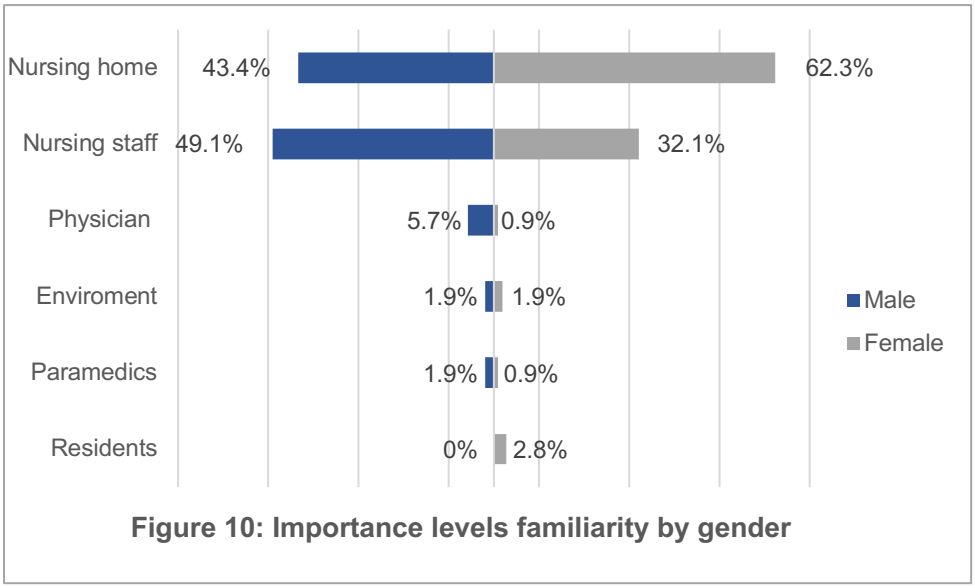

Figure 10: Importance levels familiarity by gender

With regard to the ten attributes, respondents with a low, middle and high educational level all attached most value to involvement in the transition process. Respondents with a low educational level indicated that familiarity and the ability to continue their life were equally important and were placed second. For the respondents with a middle and high educational level, familiarity was second most important and communication was third most important. This was different among the low educated respondents who gave a lower priority on communication (figure 11).

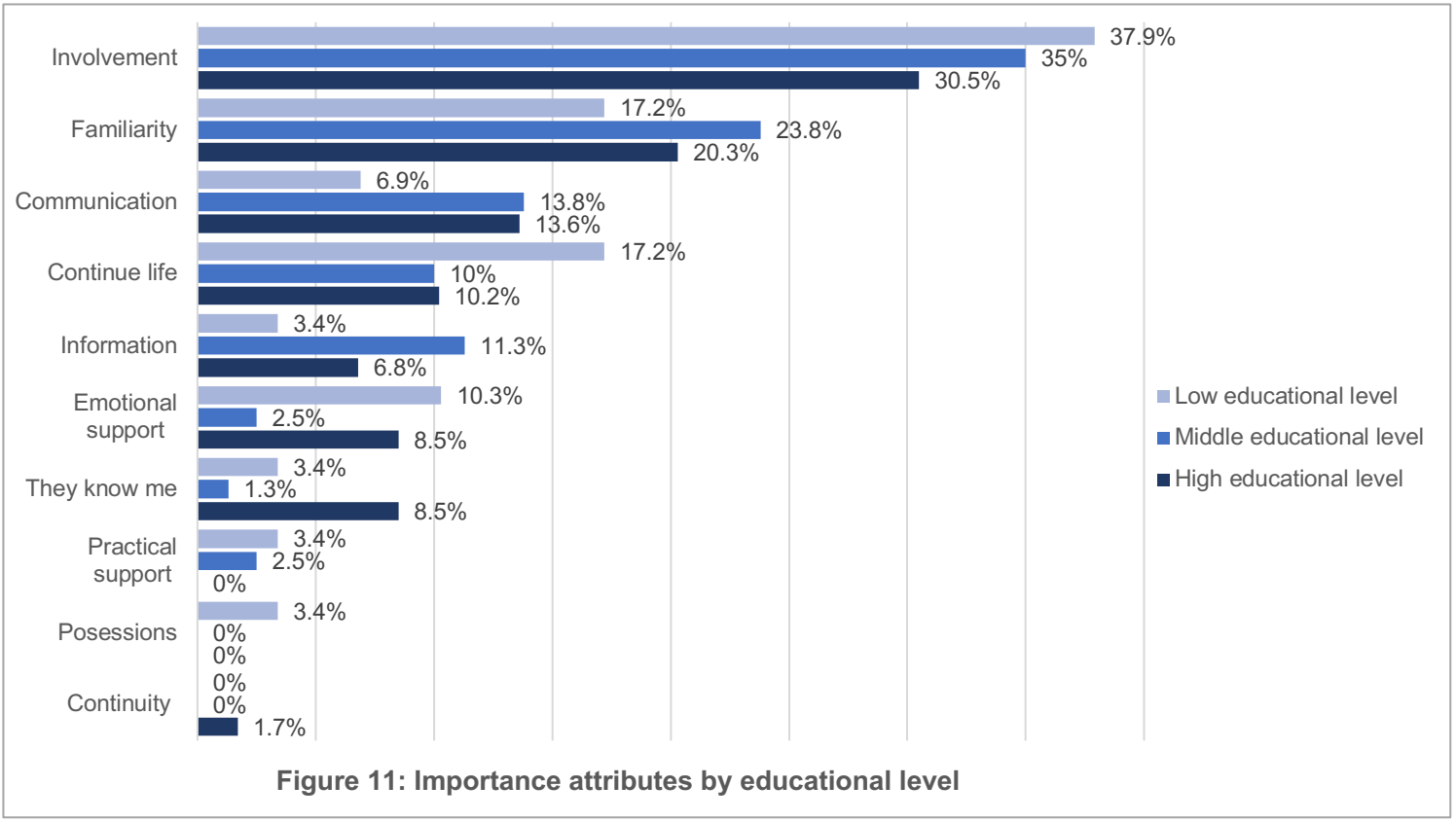

Figure 11: Importance attributes by educational level

With regard to communication, respondents with a low educational level found the channel, having a contact person and the ability to ask questions most important. Middle and high educated respondents considered having a contact person most important, followed by the channel and the opportunity to ask questions (figure 12).

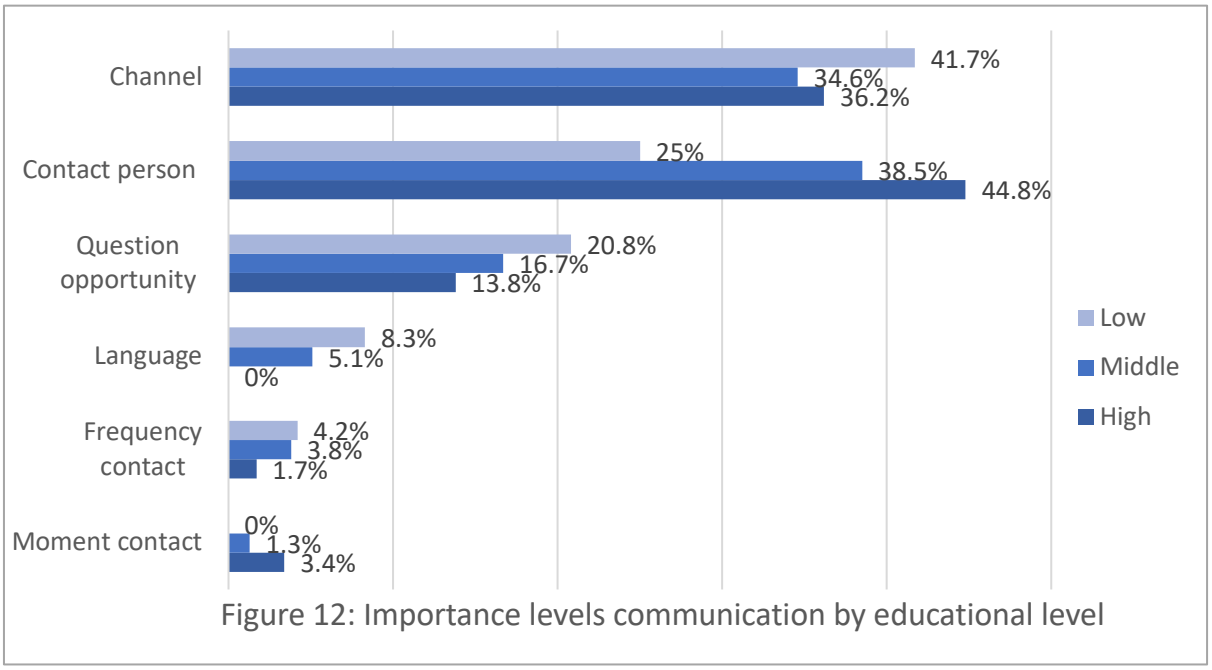

Figure 12: Importance levels communication by educational level

The percentages within the levels of information were more divided among educational level (figure 13). Low educated respondents considered the language use the most important, followed by completeness of the information. Middle educated respondents indicated completeness of the information as the most important, followed by the language use. High educated respondents also indicated the completeness of the information most important, but considered the relevance of the moment when they receive information as second most important.

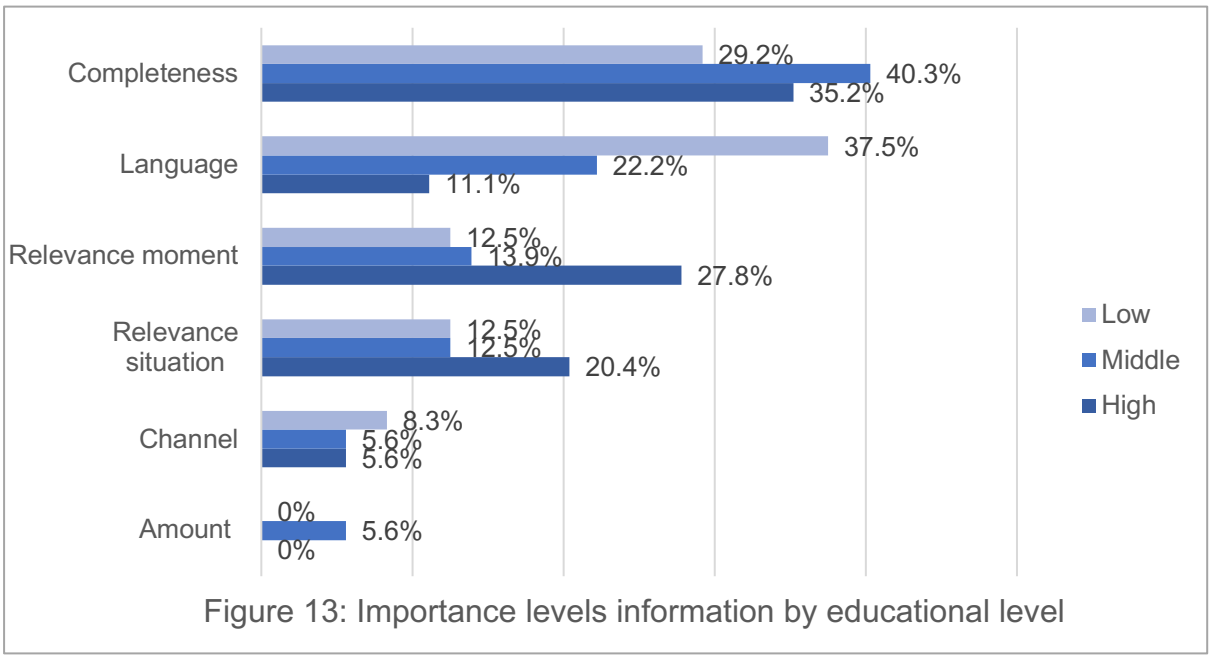

Figure 13: Importance levels information by educational level

Table 6: Satisfaction per subgroup

Variable	*Subgroup (n=total)*	*Extremely dissatisfied*	*Dissatisfied*	*Neutral*	*Satisfied*	*Extremely satisfied*
Gender	Male (n=58)	1 (1.7%)	4 (6.9%)	26 (44.8%)	17 (29.3%)	10 (17.2%)
	Female (n=111)	4 (3.6%)	8 (7.2%)	54 (48.6%)	39 (35.1%)	6 (5.4%)
Age	<60 (n=79)	3 (3.8%)	4 (5.1%)	38 (48.1%)	29 (36.7%)	5 (6.3%)
	60 or older (n=90)	2 (2.2%)	8 (8.9%)	42 (46.7%)	27 (30%)	11 (12.2%)
Education	Low (n=26)	0 (0%)	0 (0%)	10 (38.5%)	10 (38.5%)	6 (23.1%)
	Middle (n=84)	0 (0%)	4 (4.8%)	41 (48.8%)	32 (38.1%)	7 (8.3%)
	High (n=57)	4 (7%)	7 (12.3%)	29 (50.9%)	14 (24.6%)	3 (5.3%)
Relation	Spouse (n=19)	0 (0%)	3 (15.8%)	8 (42.1%)	5 (26.3%)	3 (15.8%)
	Son (n=38)	0 (0%)	1 (2.6%)	18 (47.4%)	13 (34.2%)	6 (15.8%)
	Daughter (n=79)	3 (3.8%)	7 (8.9%)	39 (49.4%)	27 (34.2%)	3 (3.8%)
	Son/daughter in law (n=11)	0 (0%)	0 (0%)	8 (72.7%)	2 (18.2%)	1 (9.1%)
	Other (n=21)	1 (4.8%)	1 (4.8%)	7 (33.3%)	9 (42.9%)	3 (14.3%)
Indication	Psychogeriatric (n=50)	1 (2%)	4 (8%)	22 (44%)	19 (38%)	4 (8%)
	Somatic (n=35)	2 (5.7%)	1 (2.9%)	20 (57.1%)	10 (28.6%)	2 (5.7%)
	Unknown (n=81)	1 (1.2%)	7 (8.6%)	36 (44.4%)	27 (33.3%)	10 (12.3%)
Living years	1 (n=71)	2 (2.8%)	5 (7%)	34 (47.9%)	23 (32.4%)	7 (9.9%)
	2 (n=29)	1 (3.4%)	0 (0.0%)	15 (51.7%)	12 (41.4%)	1 (3.4%)
	3 (n=22)	0 (0%)	2 (9.1%)	10 (45.5%)	8 (36.4%)	2 (9.1%)
	4 (n=16)	1 (6.3%)	2 (12.5%)	8 (50%)	5 (31.3%)	0 (0%)

	5 (n=9)	0 (0%)	0 (0%)	3 (33.3%)	3 (33.3%)	3 (33.3%)
	More than 5 (n=16)	0 (0%)	2 (12.5%)	7 (43.8%)	4 (25%)	3 (18.8%)
Route	Home regular(n=54)	1 (1.9%)	3 (5.6%)	27 (50%)	18 (33.3%)	5 (9.3%)
	Home crisis(n=22)	1 (4.5%)	0 (0%)	9 (40.9%)	7 (31.8%)	5 (22.7%)
	Hospital(n=31)	1 (3.2%)	3 (9.7%)	15 (48.4%)	11 (35.5%)	1 (3.2%)
	Rehabilitation (n=39)	1 (2.6%)	3 (7.7%)	18 (46.2%)	13 (33.3%)	4 (10.3%)
	Transfer (n=22)	0 (0%)	3 (13.6%)	11 (50%)	7 (31.8%)	1 (4.5%)
Region	Aalten (n=26)	1 (3.8%)	5 (19.2%)	10 (38.5%)	8 (30.8%)	2 (7.7%)
	Berkelland (n=4)	0 (0%)	0 (0%)	3 (75%)	1 (25%)	0 (0%)
	Lochem (n=32)	0 (0%)	0 (0%)	17 (53.1%)	11 (34.4%)	4 (12.5%)
	Oost Gelre (n=40)	1 (2.5%)	4 (10%)	16 (40%)	15 (37.5%)	4 (10%)
	Winterswijk (n=66)	2 (3%)	3 (4.5%)	34 (51.5%)	21 (31.8%)	6 (9%)

6. Discussion

6.1 Main findings

For this study, three objectives were formulated. The first objective was to gain insight on the emotions and needs related to the term for the transition process. For most of the respondents, the term “admission process” was associated with a negative emotion such as sadness. Also, the majority of the respondents preferred another term to describe the transition to a nursing home. These findings are in line with findings from literature, in which it was stated that the term “admission” gives a negative association with the nursing home and therefore is no longer an appropriate term (17). The term, come to live, was chosen by the respondents of this study and fits the findings of previous research (17).

The second study objective was to obtain information about the satisfaction of relatives with the current transition process. Since the majority of the respondents were neutral or dissatisfied with the transition process, it is concluded that the transition process of Marga Klompé must be improved. This finding is in line with Vilans' expectations with regard to the transition process of Dutch nursing homes (10).

The third study objective was to determine the importance of attributes regarding the transition process from the perspective of relatives. According to respondents, involvement and familiarity with the nursing home and nursing staff are important attributes for an optimal transition process. Both, involvement and familiarity, are important interventions against relocation stress syndrome. By involving new clients in decisions and introducing them to the new living environment, anxiety can be reduced and trust can be increased (6, 8). In the communication during the transition process, respondents considered it important to have a permanent contact person during the transition process. A permanent contact person is also recommended from previous research, because many different health care professionals are involved in the transition process. As a result, elderly and their relatives lose the overview and do not know who is responsible for them and their care, which in turn creates uncertainty (19). Respondents also indicated the communication channel to be important, but from this study and previous research it did not became clear which channel is most preferred (19). But, previous research did show that the use of many different channels were experienced negative by elderly and relatives (19). Regarding information, respondents found it most important that the received information is complete. Previous studies have shown that complete information helps elderly and relatives to anticipate on the new situation (19).

6.2 Other findings

Satisfaction with the transition process and importance of attributes was influenced by educational level. In general, higher educated respondents gave the transition process a lower score compared to lower educated respondents. It is known from previous research that high educated people utilize healthcare in a different way and experience healthcare in a different way (52-54). The expectation that needs differ between low, middle and high educated, was confirmed by the results of the rank tasks from this study.

Half of the respondents did not know with what type of care indication their loved one has been admitted to the nursing home. This study did not provide insight into why respondents did not know the type of care indication. Due to findings from previous studies, it is expected that this resulted from limited involvement (15). Involvement is an important part of person-centered care which is associated with higher satisfaction(15). If the missing knowledge about the care indication indeed originated from limited involvement, this may have resulted in a negative influence on the satisfaction (15).

6.3 Strengths

When selecting the attributes, the findings of people with different gender, age, education level, ethnic background, cultural background and religion were considered. As a result, the attributes were applicable to the entire Dutch society. Consultation of the expert groups on the attributes gave a positive contribution to the content validity of the survey. Due to the study design, the chance of socially desirable answers was minimized (31). By achieving 15% more than the intended study sample, the internal validity was influenced positively and the results were representative for Marga Klompé. The result of the Cronbach's alpha indicated a high internal consistency, from which it is concluded that the results concerning the satisfaction are reliable. Because the respondents were forced to make a trade-off between the attributes and levels, the study provided relevant information for Marga Klompé with regard to the importance of attributes. Finally, research on this subject is considered valuable since an information gap in this area appeared (15, 55).

6.4 Limitations

Only relatives of elderly living in the Oost-Achterhoek were approached what resulted in a selection bias and caused a limited generalizability since the results of the study cannot be applied to the entire Dutch society. This is reflected by the fact that only one person with a migration background participated in the study. But, beside the choices in recruitment and sample size, this may have arisen from other reasons. In general, the response rate is lower among people with a migration background (56). Also, the percentage of people with a

migration background in the Oost-Achterhoek is lower than in the rest of the Netherlands(57). Moreover, people with a migration background make little use of nursing homes because it is common for children to take care of the elders and these people experience difficulties in gaining knowledge or getting access to a nursing home due to language barriers (58).

This study provided insight into which attributes and levels are important to respondents, but the study did not provide insight into what form these attributes should be presented to new clients. Certain attributes speak for themselves and can easily be translated into practice. This concerns, for example, having a contact person. For some other attributes it is currently still unknown how these should be offered to new clients. This concerns, for example, the type of communication channel. This limitation arose because a criterion of the study was to keep burden for respondents low as possible and choices had to be made. Additional questions could have provided more information, but would also undesirably increase the burden.

By not including the demographic question about age at the start of the study, it is unclear to what extent educational level had an influence on the drop-out. This is unfortunate since the level of education had a significant influence on the results. In addition, the distribution of education level in this study is not comparable to that of the Dutch society (59). In general, the response rate among the low-educated is often lower compared to the highly educated (56). But in this study, the percentage of respondents with a low educational level is comparable to that of the Dutch population, the middle educated seem overrepresented and the highly educated seem underrepresented(59). Information about the drop-out based on educational level could have provided clarification on this.

Respondents who experienced the transition process 4 years ago or more than 5 years ago were more often dissatisfied but also more often extremely satisfied compared to respondents who experienced the transition process 1 year ago. These scores for satisfaction might be influenced by recall bias.(31). But, another potential explanation could be the influence of the financial situation in the elderly care at the time a respondent experienced the transition process (60). About 5 years ago, Marga Klompé started with a different working method for employees. In this period, it was not possible to consequently fill vacancies with a trained first responsible nurse. The absence of competent or trained personnel can affect satisfaction (18, 25). But, it is not clear from this study whether the different satisfaction scores were caused by recall bias or the financial situation. This makes it difficult for Marga Klompé to determine whether they should undertake an action on this.

6.5 Clinical implications for Marga Klompé

Since the majority of the respondents were neutral or dissatisfied with the transition process, it was recommended to Marga Klompé to develop an improvement plan on the transition process. The definition, which was drawn up in collaboration with expert groups, should be used as an objective to which criteria will be attached that Marga Klompé wants to meet with regard to the transition process. Defining and specifying are important steps for implementing an intervention such as an improved transition process(61).

A second recommendation is to adopt “come to live” as a new term to describe the transition process to a nursing home. This study does not reveal whether a different term would actually cause respondents to feel a different emotion. Nevertheless, it can be substantiated from previous research to apply another term since a different term for describing a care process can lead to a more positive association with the care that will be offered (62). In various studies respondents say that they consider the term used for a certain (health) care process to be important in their overall experience (20, 62). The results of the study by Maciasz et al. for example, which focused on the term “palliative care”, showed, that a different term for describing a certain care process can ensure that patients enter this process with a different and more positive perception (62).

According to respondents, involvement, familiarity with the building and nursing staff, the communication channel, a fixed contact person, use of language and completeness of information are the most important for optimization of the transition process. A third advice is to integrate these attributes, in a (renewed) transition process, because results from previous studies confirm that these attributes contribute to optimization of the admission process (7, 14, 16-29).

Low, middle and high educated indicated different needs with regard to the transition process. In practice, it can be challenging to meet the needs of people with different levels of education, but the advice is to implement these attributes in the transition process to comply with person-centered care. Marga Klompé could do this by asking for these attributes during the transition process. Regarding “continue life”, for example, the new client could be asked about the things he would like to continue from home when moving into a nursing home.

Compared to other regions, Aalten had the most respondents who were dissatisfied and the least respondents who were extremely satisfied. Lochem, for example, had no dissatisfied respondents and the highest percentage satisfied respondents. These results may be an indication that the transition process is performed differently within the regions and that

particular regions may better suit the needs of clients and relatives. It is recommended to perform field research in every region so that the working methods per region can be mapped and analyzed.

Another advice is to provide the elderly and their relatives with good information about the care indication. Providing person-centered care goes hand in hand with informed consent and shared decision making. However, Half of the respondents did not know with what type of care indication the client had been admitted. So, relatives may not be fully aware of the different types of care indications and might not know what expectations they should have of the care. This affects the extent to which they can take an active role in decision-making(63). The frontline desk is responsible for the application of a care indication. The advice is that they must inform and involve new clients and relatives more in this process.

It is valuable to know which attributes are important for optimizing the transition process from the perspective of relatives. But respondents' views and opinions on care are changing over time (64). That is why the last advice to Marga Klompé is to continue evaluation on the transition process on a structural basis, so they remain informed about the satisfaction and needs of their clients and relatives.

6.6 Scientific implications

In the preparations for this study, no preference studies were identified with regard to the transition process to a nursing home, conducted from the perspective of elderly and / or their relatives. A recently published study acknowledges the existence of an information gap in the involvement of older people in research and decision-making (15).

To provide good quality of care to elderly, evidence on the involvement of elderly in decision making on health care processes is needed by health care professionals, policymakers and researchers (15). However, in the past, elderly people were often excluded from studies (15). Due to frailty, cognitive problems and communication problems, involving them was not seen as an added value in the field of research and development (15). But this is expected to change. Demographic changes and increasing life expectancy results in a need for research into the preferences and experiences of the elderly(15, 65).

More preference research to the subject will contribute to the development of high quality of care (15, 55). It matters from which position people reason when improving care. People with a need for care consider different things important than people who are healthy (55). Therefore, the provision of high-quality care can only be fulfilled when working from the

perspective of the elderly (55). This underlines the importance of future preference studies with the involvement of elderly. Important steps have already been taken, such as the development of guidelines that were specially written for conducting research among elderly (66).

7. Conclusion

Slightly less than the majority of the respondents were satisfied with the transition process. Respondents chose “come to live” as a potential new term. According to respondents, involvement, familiarity with the building and nursing staff, the communication channel, a fixed contact person, use of language and completeness of information are the most important for optimization of the transition process. Satisfaction and importance of attributes were influenced by a high educational level. A review of the literature revealed an information gap on the subject. Due to a changing perception on involving elderly in research, an increase of studies into this target group is expected.

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Appendix 1.

Mini review

Literature such as reports and guidelines from government agencies, professional associations and patient associations were used to determine search terms for the mini review. According the suggestions made by Griffiths, arbitrary limits were applied during the mini review.(30) The following search terms have been extracted from the orienting literature and were used for the search in the databases: “patient” OR “elderly” AND “preference” OR “experience” AND “admission” OR “transition” AND “nursing home” OR “long term care”. These terms were entered in Google Scolar, PubMed, ScienceDirect, Scopus and Web of Science. Years published was limited from 2000-2020. Only English or Dutch written text was included and only the titles of the 50 first results were assessed.

The table below show an overview of the results from the databases.

Database	**Search strategy:** *Year 2000- 2020, view in database based on relevance, English written*	**Search terms:** *“patient” OR “elderly” AND “preference” OR “experience” AND “admission” OR “transition” AND “nursing home” OR “long term care”*	**Search Results (n)**	**Accepted based on title (n)**	**Accepted bases on abstract (n)**	**Accepted based on total content* (n)**
Google Scolar	All criteria used	All search terms used	17.600, only 50 first results were assessed	39	23	11
PubMed	All criteria used	All search terms used	39.896, only 50 first results were assessed	15	9	4
ScienceDirect	All criteria used + following article types selected: review articles, research articles and mini reviews	All search terms used	1.806.229, only 50 first results were assessed	3	1	0
Scopus	All criteria used + following article types selected: articles and reviews	All search terms used	770, only 50 first results were assessed	9	8	1
Web of Science	All criteria used + following article types selected: articles and reviews	All search terms used	1,452,198, only 50 first results were assessed	8	2	1
Total	-	-	250	74	43	16

**Reasons for exclusion were irrelevant country, research group or care setting, no open access and duplicates.*

13 of these articles were qualitative studies conducted through interviews. The other 3 articles were literature reviews.

Appendix 2.

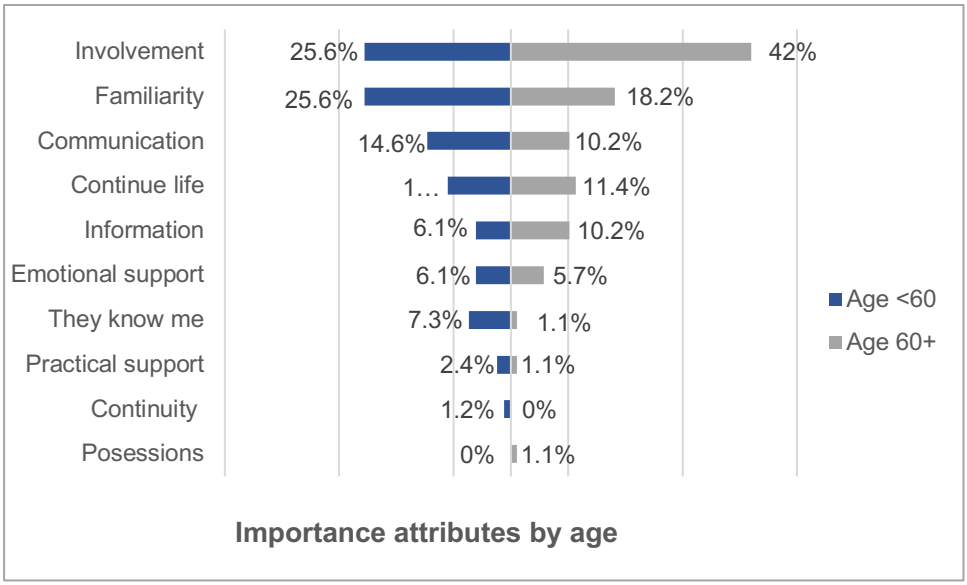
Old and new variables

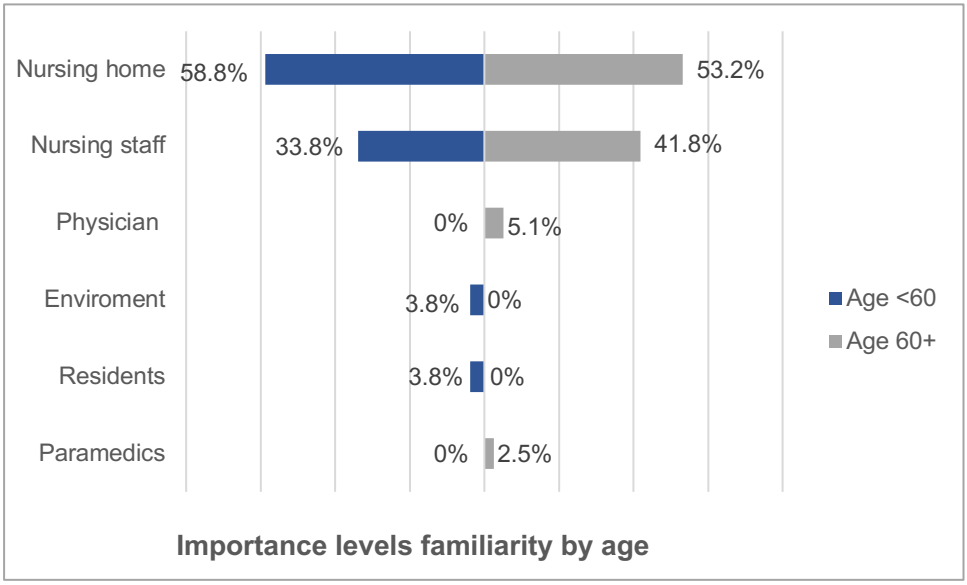
Old variable	Old subgroups (coding)	New variable	New subgroups (coding)
Age	<20 (1) 20-39 (2) 40-59 (3) 60-79 (4) 80+ (5)	Age2	<59 (1) 60+ (2)
Education	Primary school (1) VMBO (2) HAVO (3) VWO (4) MBO (5) HBO (6) WO (7)	Education2	Primary school and VMBO = Low educational level (1) HAVO, VWO and MBO = Middle educational level (2) HBO and WO = high educational level (3)
Relationship	Spouse (1) Son (2) Daughter (3) Son in law (4) Daughter in law (5) Grandchild (6) Other (7)	Relation2	Spouse (1) Son (2) Daughter (3) Son in law and daughter in law (4) Grandchild is merged with other (5)
Chronic care indication	ZZP5 (1) ZZP6 (2) ZZP7 (3) ZZP8 (4) ZZP9 (5) Unknown (6)	Indication2	ZZP5 and ZZP7 is merged into psychogeriatric indication (1) ZZP6 and ZZP8 is merged into somatic indication (2) ZZP9 (3) Unknown (4)
Living years	1 year (1) 2 years (2) 3 years (3) 4 years (4) 5 years (5) 6 years (6) 7 years (7) 8 years (8) 9 years (9) 10 years (10) <10 years (11)	Living years2	1 year (1) 2 years (2) 3 years (3) 4 years (4) 5 years (5) <5 years (6)
Progress survey	Range from 0-100%	Completed	100% (1) means completed 0-99% (2) means not completed

Appendix 3.

Additional graphs for the importance of attributes and levels per subgroup

Age





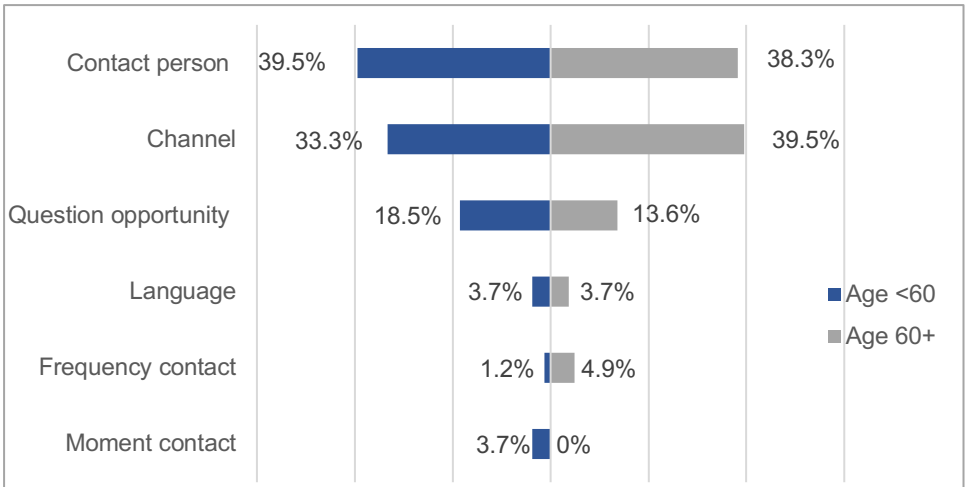


Figure 8: Importance levels communication by age

Gender

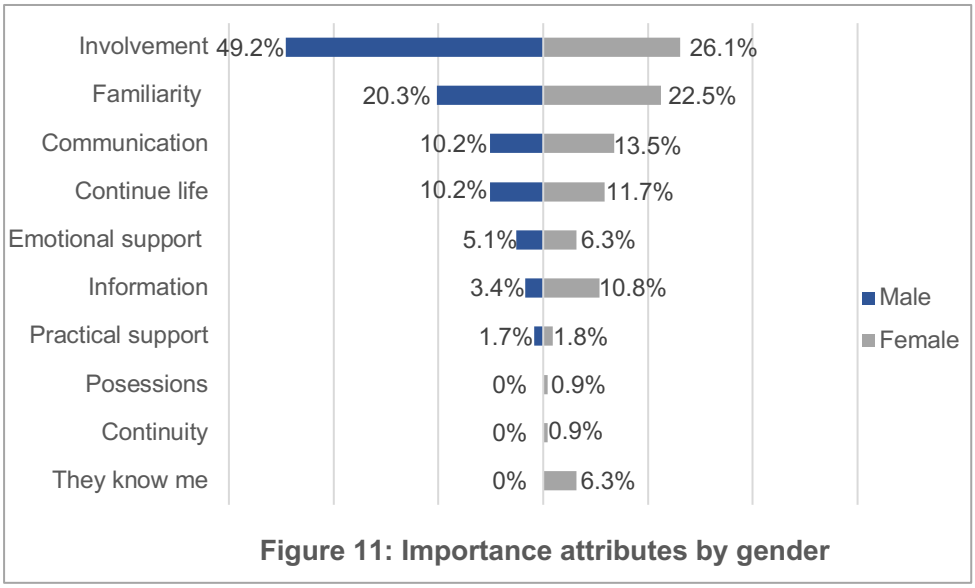


Figure 11: Importance attributes by gender

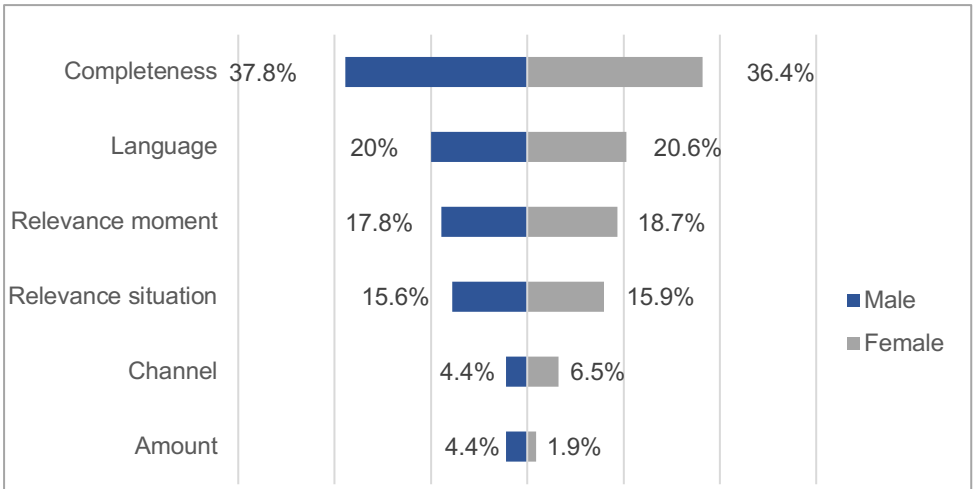


Figure 13: Importance levels information by gender

Educational level

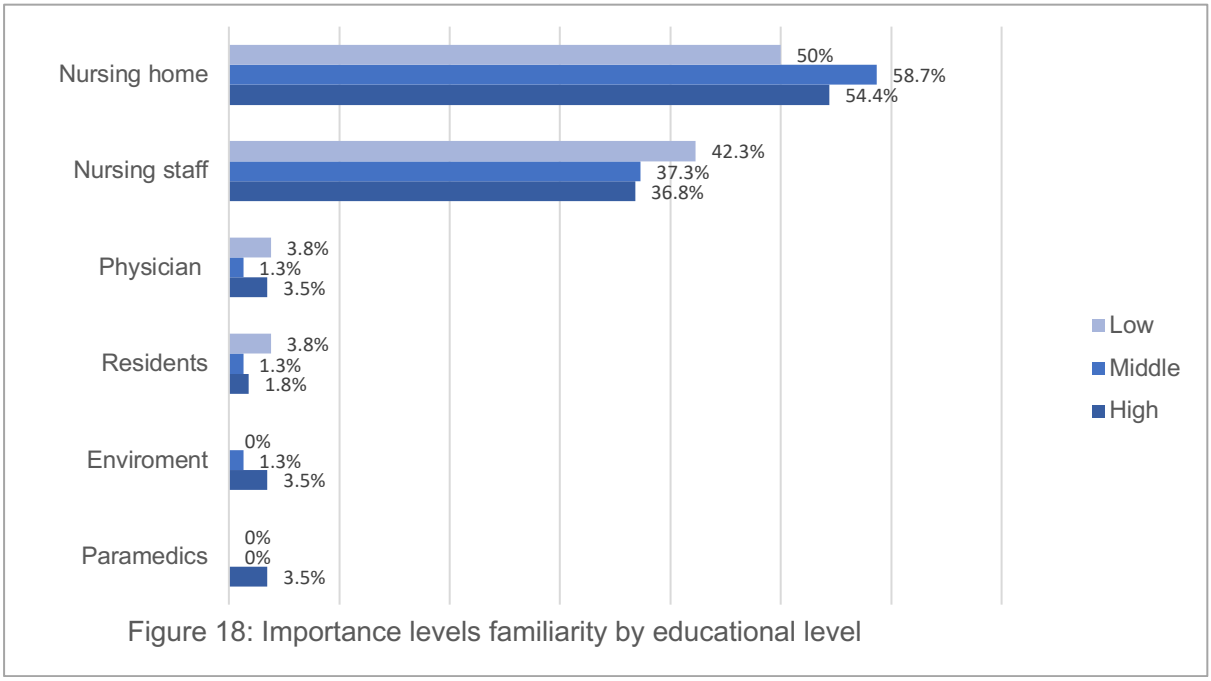


Figure 18: Importance levels familiarity by educational level