narrative learning, development, and accountability in nursing home care

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Introduction

In long-term care, a transition is happening from a traditional focus on health, protocols, and similar care for everyone to a greater focus on well-being, relationships and person-centred care and support. The shift is clearly reflected in the mission statements of nursing home care organisations and in the Kwaliteitskader Verpleeghuiszorg 2021 (Nursing Home Care Quality Framework 2021).
For many care organisations, however, it remains a challenge to make this happen in both day-to-day care and the annual quality improvement process.

Since 2017, Leyden Academy on Vitality and Ageing has been developing concrete tools for nursing home care in which well-being, relationships and person-centred care are central. These tools were tested in practice and developed using practical experiences from the work floor. In the projects 'Enjoying Life Plan' (2017-2019) and 'Enjoying Life Plan on location' (2019-2021), the so-called 'Enjoying Life'-approach (Dutch: 'Leefplezierplan') and an implementation toolbox for the approach were developed. The 'Experiences in Practice' project (2019-2020) experimented with various forms of reporting that are in line with working on life enjoyment[1].

In the above projects, the foundations were laid for working with stories from staff, residents, and relatives about life enjoyment, job satisfaction and the personal perception of quality of care. We learnt that working with these stories leads to a greater focus on well-being, relationships, and person-centred care and that it contributes to securing the life enjoyment approach. In doing so, we learnt that the stories of staff, residents, and relatives about their experiences in care can be an important source for quality improvement.

The Quality Framework for Nursing Home Care endorses the importance of personal experiences of staff, residents and relatives in understanding and improving quality. However, the design of this process is not concretised. In the project 'Narrative accountability in practice' (2020-2022), we therefore worked on developing a method for quality improvement and accountability that focuses on the experiences of the people who matter most in nursing home care: staff, residents, and their relatives. In this book, we share the project's findings and recommendations.

Good test result

I walked into your room and asked you whether you remembered being tested for corona the day before. You remembered. Then I told you the outcome was okay. This made you very emotional, you were visibly relieved.

1 Read more about the various projects regarding the 'Enjoying Life'-approach here: **www.leefplezierindezorg.nl/projecten** or scan the QR code

Project objective

In the current evaluation of nursing home care quality, the focus is on information we can report in quantities and numbers, such as medication safety, bedsores, attention to eating and drinking and the residents' happiness. This information allows us to aggregate data into key figures that can be benchmarked. But these figures don't do justice to the perspectives of staff, residents, and relatives in regard to the quality of care. The stories of people about their experiences with care and support provide far more insight into the complex and personal perception of quality of care than numbers ever could.

Traditionally, experiences of care and support are collected incidentally and on a small scale, through interviews or focus groups. These traditional methods provide leads for improving care and support for individual residents but lack sufficient scale to draw conclusions about quality at team/location/organisation level. In the current project, our aim was therefore to develop a method for quality improvement and accountability in which working with experiences is part of:

1. the daily practice of staff, residents and relatives;
2. the process of quality improvement and accountability of an entire location and/or organisation.

This means that the method should be designed so that the experiences of staff, residents and relatives can be used for different purposes and at different levels:

- Being able to share and view experiences in an accessible way for jointly shaping care and support (micro level) and reflecting on the care provided and collaboration (meso level).
- Being able to select and analyse experiences using metadata to map the care and support provided for quality policy purposes (macro level).

The SenseMaker® method and app[2] offer this possibility by connecting narratives with numerical information. The idea is that people share their experiences in response to an open-ended question (narrative information) and then provide metadata by answering interpretation questions (numerical information). When you do this digitally, an infinite number of experiences can be captured, that can be navigated based on the corresponding metadata. In our project, we have used the SenseMaker® method and app as the basis for developing our method for quality improvement and accountability.

By working directly together with staff, residents and relatives on substantive development, organisational integration, and technical realisation, we aim to develop a method that suits those involved in nursing home care. In our action research, planning, action, observation, and reflection are steps to be followed in a continuous process, each time in close cooperation between the different stakeholders in the project. The project took place from January 2020 to April 2022 at 'De Den', which is part of the Quintus location of Respect Zorg, and 'Madelief', at the Campanula location of ZZG Zorggroep. The project was financed by the Dutch Ministry of Health, Welfare and Sport.

2 The SenseMaker® method was developed by Prof Snowden and his company Cognitive Edge. For more information on the method see: **https://thecynefin.co/sensemaker-2/** or scan the QR code

Parties involved

Subsidy provider

The project 'Narrative accountability in practice' has been financially enabled by the Dutch Ministry of Health, Welfare and Sport (VWS). The project follows two other projects carried out by Leyden Academy in close cooperation with the Ministry of Health, Welfare and Sport in recent years: 'Enjoying life plan for care' (2017-2019) and 'Enjoying life plan on location' (2019-2021). We worked closely with Theo van Uum, Rick Hagelstein, Anja Kohler-Cornelissen, and Johan Ulenkate in the coordination around these projects.

Participating healthcare organisations

De Den

Ward De Den consists of two connected corridors ('Noorder Den' and 'Zuider Den'), with a total of 26 residents with psychogeriatric problems. Both corridors have their own living rooms. De Den employs about 25 permanent members of staff and several students, and flex workers are an important part of the team. The team is managed by a team manager. De Den has participated in the 'Enjoying life plan for care' project. In recent years, the organisation has been working to roll out the life enjoyment approach in other wards and locations.

Madelief

Eight people with psychogeriatric problems live on the Madelief ward, all of whom have their own apartment and meet in the communal areas. The staff team consists of eight permanent members of staff and one apprentice and is managed by a location manager. Madelief took part in the 'Enjoying life plan for care' project. In recent years, the organisation has been working on rolling out the life enjoyment approach to other wards and locations.

The collaboration

At De Den, we worked closely with staff members: Adrienne Pronk, Ana Smolinska, Angela van Renesse-van Duivenbode, Jacqueline van den Berg, Mike van Zon, Monique van Bussel and Shirley Toet-Dijkhuizen and team manager Frances van Balen. At Madelief, we worked with staff members: Ester Tadlaoui-Endrino y Patino, Esther Visscher-Hermsen, Kelly Wolfraad, Miranda Cobussen, Sabine Scheermeijer-Spoeltman, Simone Husman, Wilma Weideveld, case manager Anneke Lanters and team manager Dayenne Versleijen. At the organisational level, we had regular meetings at Respect with director Klaas Smilde and quality manager Roland Lameijn, and at ZZG with director Hans Vos, project supervisor Ria Rutten and quality manager Marieke van Haaren.

The research team

The Leyden Academy research team consisted of PhD students Marleen Dohmen and Charlotte van den Eijnde, researcher Marije Blok, narrative researcher Friso Gosliga and senior researcher Josanne Huijg. The project involved close collaboration with Cognitive Edge researchers and developers, including Dave Snowden, Beth Smith and Ken McHugh.

Friso and Marleen were responsible for the **substantive development** of our method. Together they organised various activities in which the entire research team participated to develop the experience questions and interpretation questions that staff, residents and relatives worked with.

Marleen and Charlotte have been busy over the past two years with the **organisational incorporation** of our method in the participating wards and locations. This involved working with staff on a daily basis, to develop our method, working methods for its use in practice and supporting the staff in working with experiences. This included coaching the staff, organising group meetings, facilitating reflection discussions, making teaching materials and holding (evaluation) interviews. Marije had the lead in researching the role of residents in working with experiences and supported Marleen in researching the participation of relatives. Together, Friso and Marije held discussions with (quality) managers, directors, and the various other parties on the use of our method for quality policy.

Friso had the lead in the **technical realisation** of our method. Friso is the Dutch 'SenseMaker® hub' and the linking-pin with Cognitive Edge. He used his Dutch network and worked with UX designers to help make the app suitable for the stakeholders and the context of nursing home care.

Josanne managed the team and helped out where she could. She maintained contact with the subsidy provider and with the members of the research network for the use of narrative for the evaluation of quality of care[3]. Finally, Josanne coordinated the creation of the final document and edited the texts by Marleen, Charlotte, Marije, and Friso.

3 More information on the network can be found at **https://www.linkedin.com/groups/12585696/** or scan the QR code

Reading guide

In this part of the book, you will find our 'Narrative accountability in practice' project report.

In **Chapter 1**, we share the principles of the method we developed to use the experiences of staff, residents and relatives for quality improvement and accountability.
In **Chapter 2**, we provide an overview of our 'Experience Matters' method, consisting of the 'experience cycle' for working with experiences in daily practice by staff, residents and relatives and the 'quality cycle' for the purpose of quality policy and accountability by (quality) managers and directors.
In **Chapter 3** we describe the path we took to arrive at the substantive development, organisational incorporation, and technical realisation of the method.
In **Chapter 4** we summarise the results and formulate our conclusions and recommendations.
In **Chapter 5**, we describe working with Experience Matters in a broader perspective.

Throughout the book, we also share the experiences members of staff have shared throughout the project. These photos and short pieces of text offer a glimpse into the content of working with Experience Matters and the value of our method in a practical environment.

If you open the book on the other side, you will find a carefully crafted 'Activity Book' that healthcare organisations can use when they want to get started with the Experience Matters approach. In the first part of the Activity Book, we share practical tools, exercises and activities for staff to get started with the Experience cycle. The second part is aimed at (quality) managers and directors and offers support in going through the different phases of the quality cycle.

The links in the book will take you to our website www.leefplezierindezorg.nl with additional knowledge and tools for working with experiences. If you would like our support to get started with working with experiences in your own organisation, please contact **info@leydenacademy.nl**.

Showed a video of resident's daughter moving house

In these corona times we are trying out different ways of communication between residents and their loved ones. We are putting pictures on FamilyNet and allow family members to respond to those; then we show the responses to the residents. A nice experience for me was that the daughter of one of our residents had made a movie of herself moving to her new house. I showed this movie to our resident and she enjoyed it visibly. Normally, this lady often goes out with her daughters but because of corona this is not possible. She really enjoyed being able to see her daughter's new home like this, and I enjoyed sharing the experience with her.

Eating cake

Happy with her hair

I helped out a colleague to care for this lady. We put her hair up nicely, but it was not to her liking. My colleague left us momentarily. I tried to take her with us, but she didn't want to. So, I asked her how she wanted her hair to be done differently. She said she wanted it teased, so I asked her whether I could try again. I put it up again, and she was very happy.

Clipping nails

You were on the toilet in the bathroom, your hands were covered in feces and it had gotten under your nails as well. You allowed me to wash your hands, but you didn't want your nails clipped. I talked to you about this and said: "This is crazy with your nails like this." You started laughing and told me I was right. So, you let me clip your nails. I felt good about that.

Acquainted

This afternoon you have met a volunteer who has come over especially for you. This is a volunteer with a Turkish background. He greets you in Turkish. You immediately start beaming and then answer in your own language. You have a conversation together. The volunteer will come back to you next week to do an activity with you.

Witty answer

The gentleman participated in a celebration with the chaplain. He told me that there were at least 61 church services in Urk. Afterwards, he tried to show me the way to Urk. I said that he seemed to know it well. He replied with "Yes, I'm not asleep when I'm driving!" Then we laughed together. Really nice that he gave such a quick and witty answer. Little things like this make my day!

1. Principles of the developed method

A combination of numbers and narratives
In the current evaluation of the quality of nursing home care, the focus is on information we can report in statistics and numbers, such as medication safety, bedsores, attention to eating and drinking and client satisfaction. This information allows us to aggregate data into numbers that can be benchmarked, but these numbers do not do justice to the perspectives of staff, residents and relatives on the quality of care. Narrative can provide insight into the complex and personal perception of quality, but gathering narratives usually doesn't scale which makes it hard to draw conclusions about quality at a team/location/organisation level. In this project, we wanted to develop a method in which numbers and narratives can complement each other to map quality.

The SenseMaker® method and app
The SenseMaker® method is based on the combination of micro-narratives with numerical information. We therefore used this method and its associated app as the basis for developing our method for quality improvement and accountability. With SenseMaker®, people share a micro-narrative (short stories in text and images) and provide it with meaning by answering a number of questions about the narrative. The answers to these so-called 'interpretation questions' are attached to the shared narrative as metadata (numerical information). By capturing all the information in an app, the metadata can later be used to select and filter narratives, to analyse them and to discover patterns. The combination of narratives and numerical data allows for an interactive process of sense-making.

Experiences as a basis for quality improvement and accountability
Based on the SenseMaker® method, our method for quality improvement and accountability begins by collecting micro-narratives about actual events surrounding residents' care and support. This is done using an open-ended question: 'What did you do or experience today that affected you? What happened and how did you feel about it?'. We refer to the micro-narratives as 'experiences', because they are shared from the perspective of the narrator and can be about all possible events that matter to that person. To this end, experiences give insight into the goings-on in a ward, from the perspective of different narrators.

Different perspectives
In nursing home care where well-being, relationships and person-centred care and support are key, the staff, residents and their relatives play an important role in shaping and evaluating quality of care. Their experiences are therefore central to the method we developed. When a large number of experiences are collected from the perspectives of members of staff, residents and relatives, a rich picture of the personal experience of quality of care emerges. Quality can have different meanings at different levels: at the level of the resident, the ward, a location, and the organisation.

Further development of the app
We make use of the SenseMaker® app to capture experiences and metadata. Whereas the regular SenseMaker® app is mainly used to store and analyse research data, in our project the functionalities of the SenseMaker® app have been extended for use in nursing home care. This means that members of staff, residents and relatives can not only share their experiences and metadata in the app on a daily basis, but also that they can view and analyse all the experiences and metadata they have access to in a dashboard at their convenience. Moreover, other users, such as managers and administrators, can use the app to select experiences, analyse them and discover patterns.

Quality improvement and accountability at different levels
Our method, by connecting experiences and metadata, allows the information collected to be used at different levels:
- **Micro**: experiences of staff, residents and relatives can be used to shape care and support around individual residents.
- **Meso**: in a team, experiences around the care and support of multiple residents can be used to reflect on the care provided and cooperation between them. Metadata can be used to select meaningful experiences. By doing so, we are not only learning about the wishes and desires of residents, but also about the actions of staff members in the team.
- **Macro**: at a location/ward and/or organisation, experiences and metadata can be used to map all care and support provided. Metadata can be used to identify trends and patterns. Experiences then provide content and context.

Quality improvement and accountability
The recorded experiences and metadata can be used for various purposes: for shaping care in the triangle of staff, residents and relatives, for learning and development in teams, for internal evaluation of quality policy and for accountability to internal and external supervisors. This means that the content of experiences and metadata is important: it is not about helping someone out of bed and bathing them, but about how this works best for them. This involves the process of quality improvement and accountability: it is not only about the outcome of care and support, but also about how a particular choice was made. For this, narrative information is essential. Not as a matter of accountability in itself, but to initiate dialogue on quality of care with supervisors.

Identifying meaning by narrators
With our method for quality improvement and accountability, we want to support organisations in mapping quality. The SenseMaker® app allows for the capture of hundreds of experiences (which you can always re-examine) and adds the option to select and analyse these experiences using the metadata provided by the storytellers themselves. In whatever way the metadata is used, the app does not make judgements about the quality of care provided. This means that it is essential to always go back to the source of the experiences to make sense of the meaning of the shared experiences and metadata with them. This process is organised differently at the different levels:
- **Micro**: staff, residents and relatives interact to discuss appropriate care and support for a specific resident.
- **Meso**: staff interact with each other about the care provided and mutual cooperation in the ward.
- **Macro**: a group with narrators (members of staff, residents and relatives), led by the (quality) manager and/or director, discusses trends and patterns in the metadata of experiences. The experiences provide content and context for this.

In this way, our method offers the possibility of gaining insights and concrete starting points for direct action (at the micro and meso level) and for devising broader interventions to reinforce favourable (in the group's opinion) developments and dampen unfavourable ones (macro level).

2. Our method: Experience Matters

With Experience Matters, the staff, residents and relatives can use experiences to jointly shape care and support (at the micro level) and reflect on the care provided by the team as a whole (at the meso level). Managers and directors can also use experiences and metadata to evaluate the provided care for quality policy and accountability purposes (at the macro level). To this end, we have developed two cycles for Experience Matters: the 'experience cycle' and the 'quality cycle'.

2.1 The experience cycle

In Experience Matters, staff, residents and relatives engage in the experience cycle. This cycle consists of four phases. In the first phase, those involved are aware of the meaningful experiences they go through. In the second phase, they share these experiences with other people involved. In the third phase, the focus is on reflecting on experiences together. In the fourth phase, actions can be taken based on the lessons learnt.

Experiencing

The daily practice of care is a continuous sequence of events, big or small, that are meaningful to individual staff members, residents and relatives to a greater or lesser extent. Think about for instance: a compliment from a colleague, being able to inspire a resident or doing fun things together for a loved one. For each individual, these experiences contribute to the personal perception of quality of care. For our method, it is important that the people involved are actively aware of the experiences they go through, and are able to reflect on what these experiences mean to them and why.

Sharing

When staff, residents and relatives are aware of the experiences they go through, they can share them with each other. Sharing experiences is very important for jointly shaping care and support and reflecting on the care provided and team collaboration. Next to the more unconscious sharing of experiences in various conversations that take place in the day-to-day practice of care (like the various handover moments in a day, a conversation with a resident about eating or a loved one talking about what a resident's life was like at home), it is important to share experiences consciously, by recording them in a central place and making them visible to other people involved.

In our method, we use an app for sharing experiences. The app allows stakeholders to see all the experiences they have access to. This provides information and inspiration to do the right thing together regarding the care and support of residents. Other ways of sharing experiences have been explored in the 'Experiences in Practice' project.

4 Read the final report of the 'Experiences the Practice' project on our website:
https://leefplezierindezorg.nl/wp-content/uploads/2022/03/Eindverslag-Ervaringen-in-de-praktijk.pdf
or scan the QR code

Reflecting

The purpose of reflection is to be able to consciously act in a competent manner: knowing what you do, how you do it and why you do it. Sharing experiences in the app contributes to the reflection of individual storytellers by making them pause and reflect on the event they experienced. In addition, sharing (and making visible) experiences in the app contributes to reflection on the events others experience: what they do, how they do it and why they do it. This can lead to new insights and starting points for good care and cooperation, as well as questions and dilemmas.

Besides individual reflection, experiences provide a way to reflect collectively on good care and cooperation. This process of sense-making goes a step further than just exchanging experiences. In a reflection discussion, those involved do exchange experiences, but also their perspectives on these experiences, with the aim of learning and developing. This too can lead to new insights, starting points, questions, and dilemmas. In addition, reflection discussions can contribute to more insight into each other's perspective and mutual understanding.

Reflection discussions can take place between members of staff (e.g., as part of a residents' meeting) or together with various stakeholders in the triangle of members of staff, residents and relatives. Our method offers tools to initiate reflection. Stakeholders can use a guideline that focuses on three steps: review, discuss, decide.
This structure helps to move from just having a conversation about experiences (exchanging stories) toward a deeper reflective conversation about experiences (what do I think and learn from this?).

Acting

Reflecting on experiences provides insight into the actions and perspectives of various stakeholders. From this, those involved can decide (individually or jointly) that the care and support and/or mutual cooperation is already going well, or that it could be improved or that something entirely different should be tried. In the action phase, staff puts the outcomes of the reflection process into practice: they either continue as before, or stop doing something, or start doing something else. Trying this out leads to new experiences, which in turn can be shared and reflected upon. This completes the cycle of experiences.

2.2 The quality cycle

Managers and directors can work with the 'quality cycle' in Experience Matters. This cycle ties in with the quality improvement cycle described in the Nursing Home Care Quality Framework and again consists of four phases. In the first phase, managers and directors draw up a quality plan. In the second phase, they formulate interpretation questions to reflect the objectives of the quality plan. In the third phase, they work with the shared experiences and make the connection with the experience cycle. In the fourth phase, they formulate the insights gained and report them in the annual quality report.

Drawing up the quality plan

The Nursing Home Care Quality Framework describes that nursing home care organisations must draw up a quality plan every year to learn and develop. This task is usually assigned to the quality manager, who collaborates with other managers and the director for this purpose. To draw up the plan, the quality manager uses the organisation's context, care vision and core values, the previous quality report, and the input from various stakeholders inside and outside the organisation.

Among other things, the plan should address the following themes from the Nursing Home Care Quality Framework: person-centred care and support, housing and well-being, appropriate and safe care, and learning and development. For each theme, the plan should describe the direction in which the organisation wants to develop in the coming period. The key question for each theme is: *'Which (kind of) experiences would we like to see less of on this particular theme and which (kind of) experiences would we like to see more of?'* If no experiences have been collected yet (when first starting to use the method), other available narrative information can be used to find answers.

Formulating interpretation questions

Once an organisation has a clear picture of the desired direction of development for certain themes during the coming period, interpretation questions can be formulated to bring them into focus. First of all, it is important to answer the following question for each theme: *'If we do move in the desired direction, what would that look and feel like for members of staff, residents and relatives?'* The answers to this question provide insight into cross-thematic 'core concepts' for an organisation, like 'autonomy', 'cooperation', and 'connectedness'.

To formulate the interpretation questions, you can extract the desired development direction from the core concepts. For example, for the core concepts of 'autonomy', 'cooperation', and 'connectedness', this could lead to statements such as: *'If we are heading in the right direction, we expect that residents experience more freedom when it comes to decision-making'* or *'...we expect that members of staff are more positive about the relationship with relatives'* or *'...we expect relatives to feel more involved in care.'* These statements could become the foundation for new interpretation questions. Any existing interpretation questions (if the method is already in use) may be adjusted or removed during this review phase.

Applying the method

After formulating the interpretation questions, members of staff, residents and relatives can start sharing their experiences. These can then be read and analysed by (quality) managers and administrators. The central question here is: *'Do we see a development in the experiences and metadata people share and, if so, is this development going in the desired direction?'*

They can use the resulting information to reflect on the shared experiences and metadata together with the narrators, and make sense of them at the location/ward and/or organisational level (macro level). In addition, this information can be used to hold reflective conversations in teams (meso level) and/or with stakeholders in the triangle (micro level) about good care and cooperation. Team managers play an important role in the connection between the experience cycle that members of staff, residents and relatives go through and the quality cycle of (quality) managers and directors.

Formulating insights

During the quality cycle, (quality) managers can access the experiences and metadata any time they want to in order to formulate insights (supported by the information from the reflection conversations with the narrators). These insights, together with other sources of information from the organisation (think of the electronic client dossier, or a client satisfaction survey), are then used to create a quality report on a yearly basis.

After (quality) managers and the director have shared the quality report with internal and external supervisors, parties can discuss the findings with each other. In this sense-making conversation, the findings can be illustrated by the shared experiences and the corresponding learning and development process. The quality report, together with the feedback from all parties involved, then becomes the input for a new quality plan, starting the quality cycle anew.

Did chores together

Fresh air

I came to you this afternoon to turn on the lights. You looked a little sad. I sat down with you and I asked you how you were. You say things are bad. You say you would like to go outside to get some fresh air. I tell you that I can't go outside with you now because I am cooking dinner, but we can go outside for a while after the meal. You gratefully take my hand and tell me I'm sweet. After dinner I came back to help you into your wheelchair and we went for a walk outside. You enjoyed it, your mood lightened and you were happily chatting away.

Quiet

You didn't say anything during my shift today, you've been very quiet these last few days. You do make contact with gestures and eye contact, but you don't seem to feel the need to talk. I tried to challenge you in this by starting a conversation myself, but even then, you say nothing back. You do enjoy the company though, and you enjoy your dinner. When I walked you back to you room, put you to bed and wished you a good night, I was pleasantly surprised that you replied. You said "Hey, thank you." Nice to end the day like this together.

Freedom of movement

The gentleman likes wearing a t-shirt with the sleeves open at the bottom, because it gives him more freedom of movement. Unfortunately, this t-shirt was in the wash. I grabbed another t-shirt and cut the sleeves open. He was very happy and said "now I can show off my biceps!"

Preparing dinner together with a resident

Staying in bed for a while

I went to care for the lady in the morning. I came in and turned on the little light so she could wake up gently. I said "Good morning, Lady Lidy!" That's my nickname for her. I asked her whether she wanted to get out of bed, but she asked me if she could stay in bed a while longer. Yes of course, why not? She thanked me, because she likes sleeping in. She did make me promise to come back later.

3. The road travelled

In the project, we worked with two nursing home care wards on the substantive development, organisational incorporation, and technical realisation of our method for quality improvement and accountability. The three processes were carried out simultaneously in close connection and the different phases of action research (planning, action, observation, and reflection) followed each other continuously. The cooperation between the various stakeholders was very important for this.

Throughout the project, we experimented a lot and therefore constantly adjusted the content and form of the method, its associated processes, and the technology. In this way, we aimed to develop a method that suits the people and organisations working with our method. In this chapter, we describe our activities for each of the main tasks: substantive development, organisational incorporation, and technical realisation.

3.1 Substantive development

The substantive development of our method is mostly about the process of creating and testing relevant experience and interpretation questions. In this chapter, we describe the road travelled and what we learnt from it. What we did

- Drafting and testing the **experience question**.
- Breaking down **interviews with staff, residents and relatives** from previous research into 60 short stand-alone experiences.
- Conveying, clustering, and translating these 60 experiences into **content themes**, in a participatory way and together with Cognitive Edge researchers.
- Translate the content themes into **core concepts for each target group** (members of staff, residents and relatives).
- **Drafting interpretation questions** for each target group based on these core concepts and compiling them into a 'library'.
- **Selecting interpretation** questions for the first phase of the project and adjusting these questions during the project.

Two types of questions

In our quality improvement and accountability method, staff, residents and relatives share their experiences regarding the care and support of residents in response to an open question (the 'experience question'). After sharing an experience, they are immediately asked a number of follow-up questions ('interpretation questions') to give meaning to the experience. If each person involved shares an experience several times a week, a large collection of micro-narratives (narrative information in text and images) is built up. The interpretation questions make it possible to navigate through the micro-narratives, selecting and analysing them. To be able to navigate properly, we need questions that provide insight.

Experience questions

The experience question is the first question put to stakeholders. This open-ended question should entice people to share an experience. This is more difficult than it seems. In everyday life, for example, we all know *'How are you?'* as an open question, but most people respond to this with a simple: *'Good, how are you?'*.

This seems like a trivial example, but it illustrates that people do not easily share their experiences. A good experience question prompts people to narrate (it's also known as a 'prompting question'). It does so by providing some context, by appealing to emotion, and by framing the experience without being too specific..

By 'context' we mean a situation that people can easily imagine and that is related to the sharing of an experience. For example, 'When you get home tonight...' or 'Suppose you're on your bike home after work...' or 'Looking back on the past week...' – with such situational prompts, we try to get people into a reflective state of mind.

Appealing to emotion is about helping people find an experience that means something to them. Experience shows that this works by asking about strongly positive or, conversely, strongly negative emotions: 'the most frustrating event', 'the most enjoyable experience', 'the saddest incident' – or without naming the emotion itself: 'what touched you', 'what had real impact' or 'what do you remember in particular'.

Framing the topic or time period makes it easier for people to recall an experience. The question 'How have you been?' is more difficult for people to answer than 'How was your health yesterday?' - the latter question still allows for a wide range of topics, but frames both the general context and the time period.

Development of the experience question

With these concerns in mind, within this project we devised and used the following experience question for members of staff: *'What did you do or experience today that stayed with you? What happened and how did it make you feel?'*. We presented the question to care staff at the start of the project for testing. The question was sufficiently restrictive in terms of framing but at the same time it allowed for a wide range of topics.

For residents, we used the same experience question at the start of the project: *'What have you done or experienced recently that has stayed with you? What happened, and how did it make you feel?'*. Working with residents with psychogeriatric problems, it soon became clear that this question was too difficult for them to answer. In our project, we therefore experimented with various other methods of surveying residents' experiences.

With relatives, we started with a slightly different experience question: *'What have you recently done or experienced around the care and support for your loved one that has stayed with you? What happened, and how did that make you feel?'*. In response to this question, relatives mostly shared experiences about the care provided by staff for their loved ones. Because we also wanted to collect experiences about what takes place between residents and their loved ones, we adapted the question to: *'What have you recently done or experienced with your loved one that has stayed with you? This could be about experiences with care, but also about experiences between you and your loved one. What happened, and how did that make you feel?'*.

Interpretation questions

Interpretation questions are presented to narrators immediately after answering the experience question and deal with what the shared experience means to narrators. By answering these questions, narrators add an extra layer of meaning to their experience. This metadata allows us to select and navigate the shared experiences and gain new insights.

In order for the questions to fit well with the narrators' perceptions, it is important to have a good understanding of how staff, residents and relatives jointly shape care. Knowledge of the wider context is also important. You translate this information into core concepts, which form the basis for interpretation questions.

Interpretation questions deal with the experience itself, they are somewhat ambiguous and prompt reflection. For example, around the core concept of autonomy, a question could be: 'Who took the initiative in this experience?' or 'Who had the most influence on what happened?' These are questions that require a subjective judgement from the narrator and thus invite reflection on the experience.

What happens on the ward is ultimately a sum of many, many different factors; way too many to even be aware of, and all of them constantly changing. It is therefore impossible to understand all of these in advance and neatly translate them into core concepts. Nor is that necessary; you can start out with the factors you do know to be present and relevant - based on policy intentions, previous experience, or research. As people share experiences over a longer period of time, patterns become visible that can lead to new insights about previously unknown factors. Those insights can then lead to new core concepts and new interpretation questions, meaning that the set of interpretation questions is dynamic.

Interpretation questions can be both generic and specific. For example, the question whether an experience has a positive or negative bias is generally useful; the question 'who was allowed to decide in this experience' is more specific, based, for example, on a core concept such as 'autonomy'. Such a question will not be relevant to every organisation. The questions may also differ for each target group; the perspective of a loved one is different from that of an employee and the interpretation questions should reflect this.

This ties in with the purpose of interpretation questions: they are about selecting, navigating, and gaining insights into a set of shared experiences within a context; they are not purely about measuring or recording. This makes interpretation questions different from survey questions.

Development of interpretation questions

To develop interpretation questions, we started with interviews with staff, residents, and their relatives about their life; we cut these interviews into self-contained short experiences. Then, in a workshop with several experts, we reduced these fragments to several themes through a process of thematic clustering. We then re-clustered these themes. This yielded six core concepts:

- Professional well-being
- Person-centred care
- Cooperation in the triangle
- Meaning
- Social relations
- Attitude towards change

After attending a workshop about complexity and sense-making, we developed interpretation questions for each of these core concepts. Because the final questionnaire must remain concise, it is common to devise and develop more interpretation questions than can be used in one single questionnaire. We therefore created a collection of interpretation questions to choose from: the interpretation question library[5].

From this library, we chose a subset of interpretation questions to present to members of staff via the SenseMaker® app. Our starting point was to test the different interpretation questions by regularly presenting a different subset. In practice, however, we ran into the fact that the number of incoming experiences was too limited for this. Not enough experiences were recorded over time to be able to make meaningful statements about the effectiveness of all of our questions. For this reason, we chose to stay with the initial subset of interpretation questions throughout the project.

Right at the start of the project, we also tried to translate the various core concepts into questions for relatives and residents. A concept like 'autonomy' looks very different from the perspective of staff than from the perspective of residents or relatives[6]. In the project, we undertook several activities to learn more about the sharing and interpretation of experiences by residents. For this, we drew inspiration from the interpretation questions, but we chose a different form. By doing so, we were also able to test the interpretation questions for relatives, although on a less extensive scale than those for staff members.

We made several adjustments to the interpretation questions during the project. On the one hand, this was done based on direct feedback from members of staff, for instance if they really found a question too difficult, or misunderstood its intent. On the other hand, this was done based on the shared experiences and the answers to the interpretation questions. For example, when asked a multiple-choice question about perceived emotion, the option 'Other, (specify)…' was often chosen, which indicated that the narrators' emotions were not adequately represented in the answer options. We then analysed the emotions described under 'Other, (specify)…' and reworked our list of answer options for this question.

5 The interpretation question library can be accessed at **www.leefplezierindezorg.nl/duidingsvragenbibliotheek** or scan the QR code

6 As also featured in our article regarding involving residents in nursing home care: **https://www.mdpi.com/1660-4601/19/5/2876** or scan the QR code

3.2 Organisational implementation

In our project, we wanted to develop a method that fits the stakeholders and the context of the nursing home. This means that the experience cycle should fit into the daily practice of staff, residents and relatives, and the quality cycle should fit into the work of (quality) managers and directors. To this end, we undertook several activities together with stakeholders. In this chapter, we describe the road travelled and what we learnt for both cycles separately.

Incorporating the experience cycle

Staff

We started the project by incorporating the experience cycle into staff work. There were several reasons for this. Firstly, members of staff have an important role in the care and support of residents and the quality of care is largely determined by them. Secondly, unlike residents and relatives, they can be directed by the organisation to adjust their work routines. Thirdly, the corona pandemic started in the third month of our project and confronted us with security measures that made residents and relatives difficult to reach. By investing in the relationship and contact with the staff, we managed to have remote contact and cooperate well.
What we did

- **Prepare staff** from participating wards/locations through kick-off meetings.
- **Visiting the ward** to get acquainted and guide staff members in working with experiences.
- Doing **participatory observations** (a form of observation where the researcher participates as much as possible in the context under investigation). Recording these observations in logbooks and experiences in a SenseMaker® app for researchers.
- Offer **individual coaching** focused on the various stages of the experience cycle. The coaching consisted of four exercises that members of staff carried out themselves in practice, followed by an individual coaching conversation between the employee and one of us. The coaching exercises were based on the participatory observations, shared experiences and learning needs that were identified by the members of staff themselves.
- Provide **information and workshops** focused on the various stages of the experience cycle.
- **Organising several reflection meetings** to explore the best way to facilitate reflection based on the experiences in daily practice. We tried out various working methods to support reflection. We joined existing consultation moments and organised several reflection meetings in which we experimented with the duration (long-short), the number of participants (3 to 5 and 6 to 12) and the type of people involved (members from own teams, members from other teams, managers and directors).
- **Communicate shared experiences** through newsletters, posters, and a photo booklet.
- Conducting **evaluation interviews** halfway through and at the end of the project. During the first evaluation interviews halfway through the project, we looked back at what had been done and learnt so far and looked ahead to the final goal of the project and how to get there. Here, the wishes and learning needs of the care staff were central. During the second round of evaluation interviews at the end of the project, we looked back at how members of staff experienced participation in the project and they gave feedback on the Experience Matters method.

Experiencing

For members of staff, working with the experience cycle starts with 'seeing' and recognising experiences. This requires a different state of awareness, as the most meaningful moments are often hidden in everyday actions and events. Members of staff indicated that they often fail to notice these moments due to their routine way of working, the high workload or because they considered many things to be 'normal'.

So, learning to see experiences is a process of creating awareness. Joining the members of staff in the ward and doing the coaching exercises supported this creation of awareness. Members of staff and researchers interacted together about what they experienced in the ward, which made members of staff more aware of their experiences. Staff members appreciated the fact that the researchers were 'outsiders' to the nursing home. As an 'outsider', you are not part of the routine and you look at things differently, which allows you to point out experiences that are regarded as normal by staff.

A question often asked during the project was: 'What is an experience?' Staff and researchers found the answer to this question together in practice. We learnt that there are many types of experiences and that experiences do not only take place during the moments of care and support, but also during the moments 'in between'[7].

7 For a full overview of the different types of experiences, see: **www.leefplezierindezorg.nl/ervaringentypologie** or scan the QR code

As staff became more skilled at seeing experiences, they started helping others to recognise experiences. Reading colleagues' experiences also contributed to the awareness process. Members of staff learnt from each other's shared experiences what an experience 'is'.

Members of staff generally enjoyed being more aware of what they were experiencing. It brought them a new perspective to their work and increased their job satisfaction. By highlighting 'normal' interactions, members of staff became (again) aware that they do meaningful and special work, which created a feeling of pride.

> *"I like that I notice certain things more now, for example residents' emotions. It has led to an increased feeling of job satisfaction for me because I am more aware of it now. I enjoy the moments with clients more and no longer take these moments for granted."* – Staff member

> *"By reflecting on experiences and naming them, I have become more aware of them. Recording experiences has allowed me to see our clients' beautiful moments better and more sharply."* – Staff member

Members of staff commented that you can't be aware of everything you're going through in the rush of everyday life. Thus, room and time for reflection are important conditions for experiencing. There is also a downside to being aware of what you experience. For it also means being more aware of what is not going well, which can cause feelings of sadness and powerlessness.

Sharing

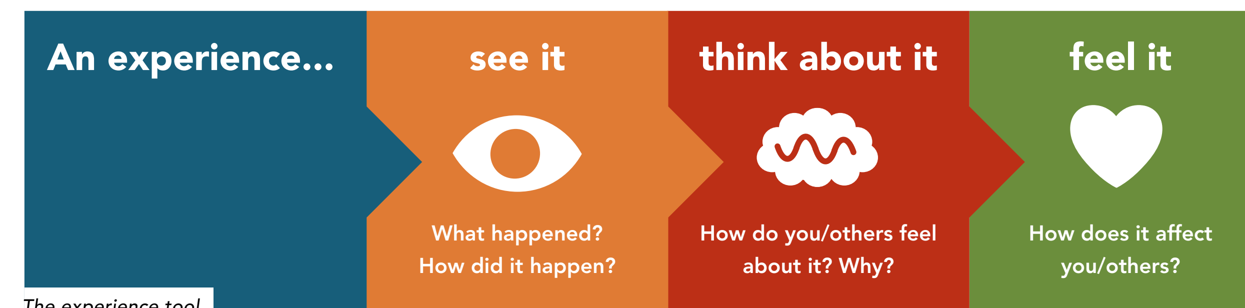
When members of staff are aware of their experiences, they can share them with each other and with others. Making others share an experience requires the skill of expressing what you are experiencing. In the Experience Matters method, experiences are expressed in text and/or photos, which are shared with each other via the SenseMaker® app.

During the project, we supported members of staff in various ways, ranging from coaching exercises, where members of staff practised putting their experiences into words, to concrete explanations and guidance such as installing and sharing an experience together in the SenseMaker® app.

Because we wanted to collect as wide range of experiences, we initially offered only a very light structure for the content of the experiences to be shared. Gradually, however, we noticed that members of staff needed more structure. For this reason, we developed the 'experience tool': a tool to describe an experience in its entirety. A written experience ideally contains the following three aspects:

1. the event: what happened and how did it happen;
2. the thoughts of the narrator and/or others involved in it;
3. the feelings of the narrator and/or others involved in it.

The 'experience tool' provides an overview of these three aspects. The experience tool can also be found in the Activity Book under the section on sharing



The experience tool

In the experience tool, the focus is on the written experience. That was also our focus at the start of the project. In practice, it turned out that members of staff especially liked sharing photos of their experiences. In fact, members of staff found the option to share photos to be of great added value. They indicated that text and images complemented each other well to provide a complete picture of a situation. Members of staff said they would like to have this option in their usual reporting system.

A learning curve could be detected in the type of experiences that members of staff shared: at first, they mainly shared pictures and positive experiences. As they became more familiar with the experience cycle, negative experiences and dilemmas followed. Confidence in the method also caused them to give their own interpretation of what an experience is for themselves. For instance, there were some members of staff who felt it was only important to share 'new' events, while others kept sharing narratives about reoccurring events.

Members of staff also went through an evolution when it came to their descriptions of an experience. In the first experiences shared, the members of staff described the event, and the thoughts and feelings of those involved, but shared little about the context of the situation. Describing the context provides proper starting points for good care. Staff themselves said that this is why they like working with experiences and that they wanted to learn how to provide better care. We paid a lot of attention to this during interviews and coaching.

We also noticed that staff didn't always mention their own contribution. For example, one staff member shared an experience about a resident who was pleased with a card she received from her husband, but the staff member did not mention that she was the one who had asked the husband to send her a card. The descriptions of these experiences also clarified the awareness process of staff members, as it became clear which aspects of a situation staff members were and were not aware of. Through coaching, making sense of the experiences, exercises, and examples in the form of colleagues' shared experiences, members of staff became more aware of the context of their experience and their own part in the experience, and learnt to give broader descriptions.

In addition, putting their own feelings into words was often a challenge for care staff. They are trained to report as objectively as possible, so they are not used to adding their own feelings to the mix. In addition, as they knew others would read along, they sought to describe their thoughts and feelings in an overly tactful and cautious manner. Again, the coaching, exercises and reading colleagues' written experiences as examples were helpful tools.

In addition to focusing on skill development, it was also necessary to inspire and motivate the members of staff involved to get them to properly share their experiences. Several factors proved important here. Firstly, our guidance and presence proved to be an important incentive, as it served as a constant motivator. By being in contact with us, members of staff were reminded to share experiences and even started to remind each other to do so.

Secondly, it was crucial for members of staff to understand the actual added value of sharing experiences. Members of staff did enjoy sharing experiences with each other, but just having 'fun' with it was not enough for them. A question that kept coming back was: 'what does it deliver?'. To answer this question, we organised moments to work together on the shared experiences.

Thirdly, the visibility of shared experiences proved to play an important role in (maintaining) the motivation to share experiences. The importance of this aspect was repeatedly confirmed throughout the project by the level of enthusiasm about the newsletters, posters and photo booklets. Members of staff themselves confirmed this: looking back at shared experiences kept the project alive in the ward and highlighted the importance of sharing experiences. In the shared experiences, staff found support, recognition, inspiration and starting points for good care. Had they not been shared, many of these experiences would have been lost.

The captured experiences could be read by using the SenseMaker® dashboard, which all team members had access to. Although the 'analogue' ways of revisiting experiences were each time received with enthusiasm, only a handful of members of staff viewed the dashboard of shared experiences. The dashboard was not accessible enough: members of staff had to find time to sit down at the computer, look up the website, enter the login details, and delve into a system that was new to them and felt a bit overwhelming.

Having sufficient time and room also played an important role in promoting sharing. When time was limited, the sharing of experiences was often the first thing to be abandoned. Many members of staff shared experiences in their own time, for instance in the evening after their shift. To make more room for sharing experiences, members of staff asked, among other things, for a link between SenseMaker® and Nedap ONS, their usual reporting system. We were able to implement this link in the test environment during the project, but not in practice. More information on this can be found in chapter 3.3 about the technical realisation.

Along with seeing experiences, sharing the experiences contributed to a process of becoming aware of what you experience in your work. Expressing a personal experience encouraged individual reflection, as did answering the interpretation questions in the SenseMaker® app.

The staff felt that sharing experiences with each other added value to resident care. Staff indicated that a lot of important information 'seeps away' due to the limitations of traditional reporting. Experiences do provide this information. Moreover, they find that experiences fit better with the work they do every day and their perspective of quality of care than the usual reporting. Experiences provide insight into the 'how' in care (e.g., how someone was helped out of bed, rather than just the fact that someone was helped out of bed) and thus provide points of reference for good care.

"You learn from each other. Like, you deal with it this way and that works. How do I deal with it? Do I do the same thing, or can I learn from how my colleague deals with it?" – Staff member

"A great example is the lady who had difficulty taking pills. If you wanted to give her pills, it didn't work, she always resisted. One colleague found out that we should put them down on the table one by one, so she can take them herself one by one. Just a simple piece of direction that resolves the whole pill-taking-thing. She then shared that in an experience. And I learnt quite a bit from that at the time: Let's try what my colleague did!" – Staff member

"As a team, we don't talk to each other very often about how you experience your work, because, yes, we are busy. You don't always speak to everyone anyway. [...] In the experiences, you can see that colleagues struggle with the same things, maybe have the same attitude towards their work, or approach things in a way that is completely different to your own. It is surprising how much you can learn from each other. We miss that at times, yes. So, I think it could prove useful." – Staff member

In addition, sharing experiences with each other proved valuable for job satisfaction. Looking back at the recorded experiences evoked memories among members of staff of meaningful moments in their work, big or small. This led to feelings of pride in several members of staff. Because there was room for sharing emotions in the experiences, members of staff felt seen and heard. For some, sharing experiences also provided relief; they wrote down difficult or sad events.

While most staff enjoyed being asked about their emotions, there were also members of staff who felt that their emotions did not matter. They say they share experiences to contribute to better care for the resident, not for themselves. Finally, sharing emotions makes one vulnerable, especially when others can read it. It is important to be aware of this and handle it sensitively.

Reflecting

We found that sharing experiences in different ways and on different levels contributes to reflection. While becoming aware of what they are experiencing and while sharing experiences with each other, members of staff reflect at an individual level. Viewing other people's experiences can also trigger individual reflection. The members of staff indicated that they particularly like to reflect on experiences that can be used as starting points for good care and support. They found the metadata less useful for this purpose.

"Share useful experiences, but also fun moments you have yourself. If you do something fun with a resident and it catches on, you can share it so it can maybe be done again. That contributes to a residents' life enjoyment. For example, Mrs. Visser's fondness for playing balloon tennis. This information was shared with other colleagues, and it became a popular activity. That is how you create beautiful things, that's the point of it." – Staff member

In addition, shared experiences can also be used for group reflection. Staff indicated that reflecting on experiences together led to a deepening of working with experiences, but also that reflecting on shared experiences contributed to even more starting points for good care and support. In doing so, group reflection proved to be an important motivator to (continue to) share experiences.

"We have a resident who received forced care, which made for quite an intense process. It was very tough because she tended to respond in a very violent way, she always resisted us. It was an arduous process to provide her with the care that she needed. So, my colleagues and I got together and shared experiences on how to make things easier, how to make the care process more pleasant for her.
While talking to each other, we figured out that we should appoint confidants within the team. Specific colleagues that she trusted, people she would allow to provide her with personal care. These confidants learnt how to connect with her and then taught other colleagues how to do the same. That helped a lot. It is now a lot easier to provide her with personal care. I can even do it on my own now. That is something I didn't expect in the beginning, if I'm very honest."
– Staff member

Experiences provided a basis for members of staff to engage with each other. Staff enjoyed sitting together, helping each other and exchanging experiences. While that was not necessarily the purpose of the method for them, they did feel that reflecting on experiences had brought something to the team that had been missed until then. They did not feel the need to reflect on the nature of their collaboration based on the experiences but did notice that talking about experiences had a positive effect on the team. Getting together, talking and reflecting had led to greater understanding of everyone's approach. It also revealed, however, that when time and space are limited, staff would rather spend their time on the residents than on (another) consultation.

In the various reflection meetings we organised, we learnt that members of staff find it fun and useful to exchange experiences in existing consultation moments, such as the residents' meeting and handover. Initiating reflection proved difficult in these moments, because the they were strongly determined by routines and the day-to-day affairs. As a result, we saw that there was little room to reflect on better care and better ways of working.

Of the other reflection meetings we organised, the short meetings (30 minutes) proved most valuable. Members of staff found these so-called mini-sessions fun and valuable because they provided new insights in a short time. Also, the sessions could easily take place between work, which was not only practical, but also provided a mental 'pause', a moment for reflection. Members of staff found the longer meetings we organised useful for discussing larger issues, such as dilemmas. Staff preferred short meetings because they were usually quite keen to get back to work.

Members of staff prefer to reflect with members of their own team. They want to involve as many team members as possible, so that any decisions taken are widely supported and they themselves are less vulnerable (more experiences shared means more anonymity). They also find involving multiple team members good for cooperation and conducive to reflection. It is nice to talk and complement each other. The more participants, the more perspectives.

However, a meeting with a smaller number of participants is easier to fit into the schedule. We also found that a large number of participants does not necessarily lead to a widely supported decision. In a meeting with a small number of participants, members of staff often felt more involved in the process and part of the decision-making process, so the outcome of the reflection process was more often translated into actual action.

Staff found it of little use to reflect on the care for individual residents (micro-level) with participants from other teams, as not everyone cares for the same residents. Staff did find it useful to reflect on residents' care and support at a meso level, as well as on other shared themes, such as corona or collaboration with relatives. We also found that reflecting on experiences is a very personal matter, which can also make it difficult to do this with people from outside your team.

According to the staff, the presence of (quality) managers and directors as participants in reflection meetings was two-sided. On the one hand, their presence offered an opportunity to show what things were really like in the wards. On the other hand, their presence made members of staff feel vulnerable, both emotionally and professionally. Members of staff do like it when someone from outside the team is involved to guide reflection meetings. Such a facilitator can initiate an equal conversation between colleagues, better than when someone from their own team acts as discussion leader.

We have developed several exercises that provide tools for reflection based on experiences. Each one contains a clear guide consisting of three steps:

1. reviewing experiences;
2. discussing them;
3. deciding based on what has been discussed.

The exercises focus on different aspects of working in nursing home care. For example, there are work formats that deal with getting to know the residents, discussing dilemmas, or focussing on qualities of the team. The work formats can be found in the Activity Book.

In our project, we found that the step-by-step guide supported the staff in the transition from discussing experiences to deciding and taking action. However, while the guide can be helpful in facilitating reflection, we also found that it leads to 'completing the exercise' becoming the main goal of the meeting. During the project, it was therefore an interesting challenge for both ourselves and the staff to strike a balance between sticking to the guide and letting go of it.

Acting

Members of staff describe 'doing the right thing' for the resident as the essence of their work. They therefore really like the fact that working with experiences provides them with starting points for shaping and evaluating the care and support for residents and for adapting their actions where necessary. For members of staff, the added value of experiences (compared to the usual way of reporting) was the deeper, richer, and clearer picture of a resident that emerged over time.

"I saw in the experiences that a colleague had solved a puzzle with one gentleman and that he had really enjoyed it. I would have never guessed that he liked puzzles. Now I can start doing that with him too." – Staff member

Staff also found experiences that contained concrete tips for good care particularly useful for their actions. For instance, the experience in which a staff member discovered a new and improved approach to giving medication to a resident was often cited as a good example of the added value of the experience cycle.

"She doesn't like it when you put her medication in her mouth, she refuses it or pushes your hands away. But when you put the medication in a row on the table, she can take it herself."
– Staff member

In the reflection discussions, staff often chose 'the problem solver' as an exercise, zooming in on a problem surrounding an individual resident which required a solution. For them, a solution to a problem was a clear outcome of the reflection, which translated well into action.

Although staff indicated that working with experiences contributes to starting points for good care and support, they did not always manage to put them into practice. Reflection on experiences mostly took place in a mental 'twilight zone', so to speak: a short moment between activities when staff had some time and space to reflect. But when they left this zone, they returned to their daily practice where the hustle and bustle of work and routine prevailed. Something was needed during these moments of reflection in order to cross over to action.

Enjoying something you like

The gentleman likes to be a clown and he brings joy to our ward. During a musical activity, he pretended to be a conductor. He clearly enjoyed this and secretly I did too.

Creative solution

The lady can no longer put her legs under the table because of her new wheelchair. To allow her to participate in the flower arranging, I took her bedside table with the adjustable table top from her room. This way, she had her own little table so she could participate! She enjoyed the flower arranging and it left me feeling good!!

Music as a lure

The pedicure came to see the lady at the end of the music activity. But the lady was still enjoying herself so much that she didn't want to go. So, I picked up the loudspeaker and started walking to her room so she could follow the music. Must have been a funny sight to see this small procession heading to her room: the pedicure with her cart, then me holding the loudspeaker and then the lady with a colleague and a fellow resident.

Sense of humour

The gentleman walks up to me, says my name and then: "Did you know there's an idiot with a cat out there, and that he does the weirdest things with it?"
I say "No." Then he says: "That cat is as dead as a doornail!" Together we laughed at this dry, witty remark. He then went for a smoke. Fortunately, the resident cuddling our plush cat didn't hear a thing.

Mother and daughter

The lady asked for help. She was on the toilet and asked me if I wanted to stay with her forever.
She said: "You are my daughter, aren't you, my child?"
I responded with: "You have two sons, don't you?
I have my own mother. She replied, in a sad tone: "Oh right, yes." To which I said: "But I will stay with you forever!" She then gave me a big kiss.

Win-win situation

I played a board game with the ladies.
Our assistant also participated and she visibly enjoyed herself. She said to me: "That was nice, next time I will play with them myself."
It is nice to see and hear that colleagues are doing more activities with the residents and enjoying themselves with those. A win-win situation.

Becoming part of the group by taking part in an activity

The gentleman doesn't participate in activities very often. But he really enjoys playing 'sit-down hockey'.
He tracks the ball intently, hits the ball back with the stick and has fun with his fellow residents. It's nice seeing him become part of the group.

First, having a clear agreement about the outcome of the reflection process proved important in order to take action. When this is not done, the outcome of the conversation often remains hypothetical. Potential starting points for good care and support are not useful, if they are not acted upon. A concrete agreement includes answering the following questions:
- What are we going to do?
- Who is going to do this?
- When are we going to do this?

Case study 1: the outcome of the reflection does not lead to action.
In conversation with each other, some staff reflected on the shared experiences around a specific resident. This gentleman had been very restless lately; he was often seen moving furniture around. After some reflection, the staff thought that this restlessness could be related to his past. After all, the resident had previously owned his own grocery shop. In his perception, he might have been working in his warehouse. The staff decided that they wanted to provide the resident with a safe environment to do his 'work', for example by giving him some empty crates and a calculator, thus giving him an outlet for his agitation. Although the staff were enthusiastic during the meeting, when questioned, no action was found to have been taken. This shows that enthusiasm alone is not always enough to move from ideas to action.

Case study 2:
the outcome of reflection does lead to action.
In conversation, some staff reflected on a dilemma about dealing with different views on 'the right thing to do'. One family member preferred that the resident stopped participating in any religious activity, because she is not religious. However, the staff member felt the resident should be able to participate, because she knew that the resident enjoyed the activities. During the reflection discussion, staff formed an idea of what would be the right thing to do here. These ideas were then turned into a concrete agreement that specified what needed to be done, who was going to do it and when it was going to be done, after which this agreement was implemented. A staff member revisited the conversation with this resident's loved one and reported back that this conversation had cleared up the dilemma. Both parties learned more about each other's perspective and had come to an agreement on the resident's attendance at the activity.

In doing so, it is important to record the agreements surrounding actions. This acts as a big reminder: if the decision is recorded somewhere, members of staff can refer to it and ask each other about it. Besides recording concrete agreements, following up and evaluating these agreements also proved important to move from reflection to action. Therefore, in addition to the 'what, who and when', a concrete agreement ideally also contains the answer to the following questions:

- **How do we keep each other informed?**
  Keeping each other informed not only serves as a reminder, but also as a way of sharing with others. In practice, we repeatedly saw that members of staff did use the outcome of a reflection discussion, but did not share it with others, so that the lessons learnt stopped with the members of staff who had been present at the reflection discussion. Subsequently, the wheel often had to be reinvented. So, follow-up is important. After all, continuing to share what you have learnt, done and experienced is what makes the experience cycle a cycle.

- **How do we know if this is 'the right thing'?**
  This question refers to the reflection component in the experience cycle. Reflecting on experiences has a moral-ethical component, namely: what is the right thing to do here? Based on what members of staff think is the right thing to do, they decide and put this decision into practice. It is then important to reflect on this again: was this indeed the right thing to do? Thinking in advance about how to know whether something is the right thing to do provides tools for evaluation, both in the action itself and afterwards in conversation with each other.

While concrete commitments can help move from reflection to action, we also learnt in our project that it is not always possible to make the outcome of a reflection process concrete. Reflecting on experiences has a moral-ethical character and is part of a process of professional development. This cannot always be captured in concrete action points, but as a whole it contributes to good care for residents and improved working for staff members.

Finding a balance in what should or shouldn't be made concrete is not always easy. Implementing and evaluating concrete agreements leads to a sense of certainty. It creates insight into what is happening and whether it is going well. Experiences containing concrete starting points for good care are therefore easier to learn from. After all, the lesson to be learnt is then explicitly described. However, concrete actions, agreements and solutions do not always do justice to the complexity of healthcare practice. Learning and development in healthcare cannot follow a blueprint and is never 'finished'. Good care is dynamic, today may be different from tomorrow, and the approach to quality improvement must reflect this.

Tension between the old and the new

Organisational incorporation of the experience cycle works best when staff have the time and room to pause and reflect outside of their routine. Because this regularly created tension in practice, the members of staff in our project looked for ways to make the experience cycle part of their routine instead. For instance, they requested a connection between the SenseMaker® app and Nedap ONS to make it easier to share experiences, they preferred to plan reflection sessions far in advance and experiences were only discussed with relatives on the designated and scheduled moments.

The desire for structural incorporation also translated into the need for staff to be unified in working with the experience cycle. Members of staff were convinced that you can only achieve something if everyone participates, both in experiencing, sharing, reflecting, and acting on experiences. Practices and decisions that did not reach the whole team were seen as less valuable by members of staff. During the project, therefore, sufficient support for the method among colleagues was an important motivator for staff.

This also created tensions. In our method, good care starts with yourself. How you experience situations has a lot to do with who you are as a person. How you share, reflect and act on those situations is just as important. It follows that care, and therefore good care, cannot be provided by everyone in the same way. That's not necessary either: precisely because not everyone is and acts the same, team members can complement each other.

These contradictions are important points of attention for anyone starting to work with the Experience Matters method. The organisational incorporation of the method produces a tension between the old and the new. Because familiarity has a strong attraction, people try to understand anything new in terms of what they already know and want the new thing to be assimilated. However, when you allow this, the innovation and the added value of the new way of working is lost.

The power of familiarity was also noticeable in the focus that the staff had when working with the experience cycle. They focused mainly on caring for individual residents and solving specific problems directly (at the micro level) while reflecting. We see the same thing in other nursing home care organisations. However, there is added value in reflecting at the meso level, for instance on the care provided on the ward as a whole or on other themes that generally play a role in caring for people with dementia. It is therefore recommended to encourage staff to do so.

Coaching and facilitation

We developed our method in close cooperation with all parties involved. This meant that we coached staff based on the principles and starting points of our method in working with experiences, but we also gave them room to let them contribute to the development, organisational incorporation, and technical realisation. This was a kind of 'double role' in which we constantly had to balance between both the need for clear structures, and a level of ambiguity and uncertainty in the context of the research.

In the evaluation interviews, members of staff indicated that our coaching was essential for them to be able to work with experiences in their daily routine and, in addition, contribute to the development of our method. They indicated that coaching is also important in other organisations that want to work with Experience Matters. The dual role of the facilitator then consists of both facilitating members of staff to learn to work with the method, and further developing the method to fit the implementation to its specific audience.

Members of staff indicated that coaching should be carried out by 'someone from outside the team'. Someone with time and attention and the skills and position to create a fair conversation between members of the teams.
This person should organise activities around Experience Matters, offer individual coaching and be a counsellor that facilitates moments of reflection. In addition, members of staff indicated that they need a 'motivator' within their team. This is a colleague who is enthusiastic about the method and who helps staff work with experiences and reminds them to record experiences.

Residents

Besides activities with staff, we also explored different ways to get residents to participate in the experience cycle. This was sometimes difficult with the SenseMaker® method and the app, especially with residents with psychogeriatric issues.
What we did

- **One-to-one activities** (by staff and researchers) with residents of the psychogeriatric ward for the purpose of raising awareness and sharing experiences.
- Experimenting with joint **sharing of experiences** by staff and residents.
- Joining an **existing discussion group** between residents on the somatic ward, led by a mental health carer – in the discussion group, people evaluate care and support but also more fundamental life issues, such as the loss of fellow residents.
- Organising a **mixed discussion group** (staff and residents) to discuss and reflect on the recorded experiences.

Experiencing

First, we experimented with staff and researchers observing residents. Here, the degree of resident participation was limited. Observers mapped residents' experiences in different ways; first without an active role and then as active participants in a situation. Passive observation did not lead to influencing the resident but created distance between resident and observer. This got in the way of interpreting experiences. In the second approach, observers played an active role in the experience, and it was more possible to involve residents in interpretation. This more participatory approach worked better.

We then tried to make residents aware of their experiences by showing them printed photos – because screens proved too difficult to see. We showed photos of recent activities and more general photos of the nursing home. For residents with psychogeriatric problems, the photos of recent activities triggered awareness of experiences. While looking at them, residents often talked about the relationships between the people depicted. Moreover, the photos prompted the sharing of personal wishes and desires. In the more general photographs of the nursing home, this did not happen..

> *"Because we showed her a picture of dinner, the resident shared her preferences for the table arrangement. This was new to us; she had never done this before."* – Staff member

In the discussion groups with residents from the somatic ward, the photos of recent activities caused a stir. Residents did not agree with photos being taken without their knowledge. They also did not always agree with the choice of subjects.

Sharing

When staff and residents work together to share experiences, this produces great conversations. They get to know each other better and residents feel heard and taken seriously, especially when they can talk about how they experienced a situation and what their interpretation is. This worked especially well when it involved a concrete activity that was taking place at the time or had taken place shortly before.

> *"I started talking to this one gentleman, I really communicated with him. I had not done that before. I sat down next to him, in his room and chatted with him for about an hour. I got to know him in a different way. He is totally in my heart now; he is a wonderful man. [...] I am sure it was a good moment for him as well. We must do something with that."* – Staff member

> *"Ask residents how they experience a situation after something happens. And do it properly, so don't immediately post that picture without checking. Don't immediately post: 'She enjoyed the movie night'. First, ask the next day: 'That movie night, what did you actually think of that?"* – Staff member

In addition to asking questions, we experimented with presenting various colours and smileys to interpret experiences. The colours worked well to start a conversation but making the link with emotions proved difficult. The smileys offered more depth in conversations about experiences, but only if residents understood the distinction between the different smileys well.

Although joint sharing of residents' experiences is of great benefit, members of staff tend to record experiences without consultation, which makes the staff's perspective dominant. Members of staff do this because they:

- think they know the residents' perspective well;
- see themselves as interpreters of the resident's voice;
- find residents' contribution to the experience insufficient;
- or have too little time to do it together.

What we also encountered is that an identical experience and interpretation was recorded for the residents present at a group activity. This seems to have been prompted by the desire to achieve a number of experiences per resident. Each resident is then simply recorded with the same comment, for example: 'enjoyed the movie night', while it concerns individual experiences.

> *"After the movie night, my colleague wrote for each resident: 'She enjoyed the movie night.' She just copied and pasted it. So, I said to one of the residents: 'I read that you had a movie night?' 'Terrible,' she said, 'someone next to me was drooling. Someone's eyes were closed!' So, I thought to myself: 'She enjoyed herself? Yeah, right.'"* – Staff member

Reflecting
In the experiments around sharing experiences together, one-to-one reflection conversations about care and support also emerged: What do you like? What could be done differently? This led to valuable contact and an experience of self-direction for the resident. Conversations with residents on the somatic ward about concrete experiences led to more depth than just conversations about daily care.

In our project, we also experimented with a discussion group for staff and residents together. Through concrete experiences, such as about the organisation of an activity, conversations between staff and residents soon turned to personal values, such as personal control, privacy, perceived freedom and contact with family. This produced greater understanding between staff and residents, and for residents among themselves.

Acting
In acting on residents' experiences, staff members play a particular role. Talking to residents about their experiences helps to decide on (possibly new) courses of action. Residents indicate that it is especially important to them that something is done with their experiences..

> *"It is important that something is done with it. That somehow things can be improved. We have talked about food so many times. But nothing is being done about it, nothing is being improved. Nothing.'"* – Resident

Relatives
In addition to activities around the participation of staff and residents in the experience cycle, we carried out several activities in the project to involve relatives as well.
What we did
- **Approach relatives** of all residents of both wards to join the project on a voluntary basis.
- **Assist relatives in sharing experience**s in the SenseMaker® app or via the internet.
- Conducting **interviews with staff and relatives** on the wishes and expectations around mutual sharing of experiences.
- Facilitating staff and relatives to **see each other's experiences** through the SenseMaker®-VPH dashboard.
- Conduct informal conversations with staff and relatives about what sharing experiences triggered in them.
- Organising **homogeneous focus groups** with staff and relatives to reflect on sharing experiences.

Experiencing
To guide relatives in becoming aware of their experiences around the care and support of their loved one, we conducted several one-to-one interviews with them.
In these conversations, relatives reported experiencing few striking and/or new experiences with their loved one. As a result, they felt their experiences added little value. It also turned out that relatives found it difficult to share experiences of concrete events related to care and support. They mainly talked about their general impressions and feelings.

Talking to relatives about their experiences raised their awareness of what they actually thought of the care and support for their loved one. In some cases, this also translated into more involvement in shaping this care and support. However, this one-on-one counselling took a lot of time for both parties.

Sharing
To learn how relatives can and want to share their experiences, we guided them in different ways in working with the SenseMaker® app. We held one-on-one conversations in which we recorded experiences together with relatives. We also asked relatives, after our explanation of the method and the app, to record one experience per week over a three-month period. We kept in touch by phone about the progress.

The one-on-one interviews with relatives in which we recorded experiences together proved effective (they yielded one or two experiences each time), but also very time-consuming. They did, however, show that relatives were very keen to share their stories about the care and support of their loved one. This story often included more than specific experiences alone. Sharing experiences with the researchers meant that relatives were also more likely to share their experiences with staff. This provided an opportunity to jointly reflect on the experience and the different perspectives on it.

The attempt to get relatives to record experiences without supervision yielded very little. Relatives reported having little motivation to share experiences and tended to forget, because there was no one to listen to them. On the other hand, relatives indicated that they did like having the opportunity to share experiences. They felt they could get their opinions out and appreciated that there was a place for their experiences as well.

The tone of the experiences shared by relatives in the app was quite negative. It was mostly about the physical care of their relatives. For example, one relative that spoke to us was very positive about the personal attention given to his mother in the nursing home but shared in the app a negative experience about her physical care.

Reflecting
During the project, we experimented for some time with a mutual exchange of experiences between staff and relatives via the SenseMaker® dashboard. We investigated whether this was supportive of reflection and the mutual relationship between members of staff and relatives. Beforehand, we gauged their wishes and expectations through interviews.

Based on the interviews, staff and relatives' wishes and expectations about seeing each other's experiences seemed to align. Staff hoped to give relatives more insight into the resident's life on the ward, and relatives also expressed their desire to learn more. In turn, relatives wanted to give staff more information about the resident and share their perspective on care and support. Staff indicated they were curious about this. Both hoped that the exchange of experiences would contribute to a better (cooperative) relationship.

In the interviews, tensions were also noticeable. Staff found it difficult to predict how sharing experiences would turn out. They mentioned that they could not or would not share everything with relatives and expressed reluctance to share experiences that might anger relatives. Relatives were afraid of offending staff, especially if they expressed dissatisfaction. They were afraid of being seen as a nuisance, resulting in a negative impact on their loved one's care.

In practice, it turned out that for staff, sharing experiences with relatives was especially valuable when it provided new leads for good care. For example, sharing the next experience with a relative led to new information about the resident's identity:

> *"She called me because she thought there was a big spider in her room. She said, 'We have a spider in the house, a very big one, look at it!' [...] I said to her: 'I'm afraid of spiders myself and now you call me to look at a giant spider?' When I went to look at the spider with her, I laughed. She said: 'Why are you laughing? You were afraid of spiders, weren't you?' So, I said, 'That's not a spider, that's a fluff moving in the wind.' Together we laughed at the fluff."* – Staff member

After reading about this experience, one of the members of her family explained that the resident probably mistook the fluff for a spider because she loves spiders and insects. This was new information for the staff.

Staff are also curious about the experiences relatives spend with their loved one outside the ward. They see this as an opportunity to learn from situations they have not seen themselves and thus contribute to good care for the resident.

The negative experiences that relatives shared in the app evoked a lot of frustration among members of staff. Staff preferred to receive negative feedback in person. Reading things on a screen often hindered the conversation about the negative experiences. The frustration over the negative experiences eventually drowned out the added value of the other experiences. The result was that staff closed themselves off to all the experiences that relatives shared and reflection on those experiences was not possible.

Another factor in this was that it was unclear to staff what was expected of them regarding the experiences of relatives. (Should they talk to relatives about what they read?) They needed more clarity on this. However, staff did feel that the experiences of relatives should not only be read, but also discussed. With each other and with the relatives themselves.

For relatives, it turned out that using the SenseMaker® dashboard was too complicated. Therefore, relatives couldn't easily access staff experiences. When they did have access, they mainly just took note of them. There was not a lot of reflection on the experiences; to do that, relatives need more tools.

Staff experiences were received differently by relatives. Some found staff experiences very similar to information that had already been shared, for example through Caren Zorgt and Familienet. They were curious to know how staff members experienced something, while the staff members' experiences were mainly about the residents. Some found staff experiences gave more insight into life on the ward and felt reassured.

As for their own experiences, relatives mainly wanted to know whether staff had seen the experiences, for example by referring to them during visits or discussing them in more depth.

Acting

Members of staff play a particular role in acting on the experiences. For example, a resident's relative had shared the following experience about how difficult he found it to bring his mother back to the nursing home after a day out:

> *"When it was time to take her back to the ward around 7.30pm, the recurring ritual began. 'Where are you taking me? Can't I stay here? Are we going home? Stay with me!' [...] The return journey is almost always unpleasant because you feel you are leaving her in an environment where she (still) does not feel at home."* – Relative

The staff member who read this experience had never noticed that it had been this difficult for the man to leave his mother. After reading the experience, she decided to sit with her from now on when her son said goodbye, so that at least he did not have to leave his mother alone. This helped a lot.

However, such actions must be preceded by reflection. If reflection on the experience is stagnant, no new options for action arise. In that case, the method has no added value at the micro and meso level.

Incorporating the quality cycle

In a series of activities with (quality) managers, directors, and various other parties involved, we explored whether and how experiences can be used for formulating policy and accounting for quality of care at an organisational level - both internally and externally. The activities started out more exploratory in nature - asking for input to develop our method - and later became more reflective - asking specifically for feedback on the development of the method and quality cycle. In this chapter, we describe the activities we undertook, and the main lessons learnt.

What we did

- Holding several **meetings with (quality) managers and directors from both participating organisations**, in which the use of experiences for the benefit of their quality policy was explored.
- Organising two **working meetings on 'good care'**, which examined the connection between the experience cycle and the quality cycle.
- Organising two c**o-creation sessions with (quality) managers and directors of various healthcare organisations**, exploring how the Experience Matters method could support the process of accountability of person-centred care.
- Collect **feedback from various external supervisors** on our methodology for the purpose of its further development.

Applying the method

To embed the quality cycle in the work of (quality) managers and directors, we mainly started working on the third phase of the quality cycle 'applying the method'. The first phase, 'drawing up a quality plan', had already been completed by the care organisations before the project started. The second phase, 'formulating interpretation questions', was an important condition for starting the project at the locations and was therefore already carried out by the researchers. We did not reach the fourth phase ('formulating insights') together.

First step was to gather experiences. Working at the macro level, analysing experiences using the metadata requires a sufficiently large number of experiences, collected over a certain time period. As this involves both narrative and numerical information, it is difficult to say exactly how many experiences are needed. This is partly a question of representation: if you want to make statements about a population of a hundred people, five experiences are not enough. It also has to do with visualisation: if you want to properly visualise a pattern, you will need at least forty to fifty points. In practice, we therefore usually use that number as the lower limit for working with metadata.

Once this number was reached, we started applying the method together with the (quality) managers and directors. The (quality) managers and directors found reading the experiences very interesting, but analysing them very difficult. Especially when they wanted to answer complex questions using the data, such as: 'To what extent did the experiences involving corona cause anxiety among residents?'.

Working with experiences, partly because of corona, often proved too time-consuming to fit into the work of (quality) managers and directors. The corona pandemic took up a lot of their time, but also a lot of mental room, so it was difficult for them to immerse themselves in experiences for long periods of time. The (quality) managers and directors did engage with the staff during the project to reflect with them on the shared experiences and metadata.

The insights gained by (quality) managers and directors by reading experiences and analysing metadata can be used as input for reflection discussions with a team (meso level), but also within the triangle of staff, residents and relatives (micro level). In this connection between the experience cycle and the quality cycle, team managers and coordinating nurses can play an important role, but this requires making it an explicit part of their job.

Although (quality) managers and directors recognise the added value of recorded experiences and metadata, it proved difficult to fit the quality cycle into their work and connect it to the experience cycle. Talking about this, they concluded that working with experiences is best seen as part of a larger transition to a learning organisation; this requires more than just introducing a method like Experience Matters. One of the organisations listed what they believe is needed in their specific context:

- Reduce the 'span of control' of team managers so they can be more involved with their teams and don't have to keep so many balls in the air.
- Sharpening the role of coordinating nurses so that they can be more involved with quality of care.
  Now, coordinating nurses are too often occupied with organisational matters (such as dealing with sickness absence and scheduling problems) that should really be handled by team managers.
- Give the coordinating nurses a role in encouraging experience sharing, in collaboration with team managers.
- Involve quality managers in the experience cycle, in consultation with coordinating nurses, to give them a formal role in learning and development in the ward. Reading and analysing experiences and discussing findings in meetings with staff are important parts of this.
- Create a consultation structure between coordinating nurses, team managers, quality managers and administrators to discuss the findings, exchange lessons learnt and link to the quality plan and report.

The connection between the experience cycle and the quality cycle

In two working meetings on 'good care', we examined the connection between the experience cycle and the quality cycle. All organisations in nursing home care strive to provide good care, but how is this expressed on the ward and what leads can be found in experiences by (quality) managers and directors?

At one organisation, members of staff as well as (quality) managers and the director participated in the working meeting. During the meeting, they all individually read through several experiences from their organisation. They then discussed these and jointly identified the themes they encountered in the experiences.

This contributed to employee development on two levels:

- on a practical level: members of staff found in each other's experiences new ideas on how to deal with the challenges in their work;
- on an abstract level: members of staff reflected together on 'good care' and concluded that it is often in the small gestures; the conversation then turned to how to make more room for this despite the workload.

The managers and directors present gained insight into members of staff' perspectives on their work, the challenges they face and two key dilemmas:

- wanting to meet residents' needs from the point of view of life enjoyment versus wanting to provide professional care to residents;
- viewing the nursing home as a community of people versus viewing the nursing home as a professional care organisation.

In the other organisation, two managers and the director participated in the working meeting. In this meeting, all three of them individually read through several experiences from their own organisation. They then discussed these and jointly identified the themes they encountered in the experiences.

Participants were particularly enthusiastic about how reading experiences reduces the distance between the ward and management, both in perception and language. They also noted that a method such as Experience Matters makes it possible to see how some rather abstractly formulated policy intentions ('we aim for more autonomy for our residents') take shape on the ward and what dilemmas this sometimes involves.

In both cases, it was confirmed that working with experiences can serve for both monitoring (a form of internal accountability) and learning and development. For the monitoring function, it is important that the interpretation questions posed to narrators have a connection to the intended policy. This is discussed in more detail in the Activity Book for (quality) managers and directors.

Accountability of person-centred care

We invited (quality) managers and directors of several care organisations to discuss how to account for person-centred care.

They agreed that narrative information plays an important role in this and find that narrative methods reflect the personal experiences of residents and relatives much better than standard questionnaires. Organisations are therefore increasingly using narrative methods (such as interviews, focus groups and making videos) to map quality of care; the disadvantage of the more traditional narrative methods is the lack of representativeness due to small numbers and the fact that they are usually only snapshots. Making videos also involves a lot of work. The Experience Matters method offers opportunities to make the sharing of experiences a more structural part of the work.

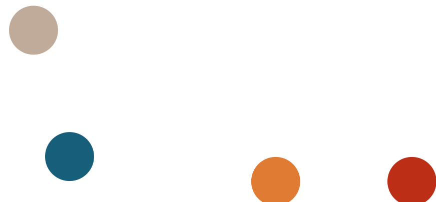
When we asked about 'accountability for person-centred care', the group indicated that the current system of accountability is not yet in line with this, as it does not provide enough room for the wishes and desires of individual residents. This is paradoxical: on the one hand, organisations are asked to provide customised care for residents, while on the other hand, the requested accountability is the same for everyone. This applies to both content (the aspects that are accounted for) and form (when, how and how frequently accountability takes place).

The managers and directors also contribute that it remains to be seen whether healthcare organisations should be 'externally accountable' for the details of person-centred care (serious incidents excluded). Most directors think it is appropriate to account to external supervisors about the lower limit of quality of care, which applies to everyone - although there are also directors who would like to see an end to all external accountability.

According to the (quality) managers and directors, accountability applies primarily towards the residents. They agree that the nursing home is nowadays, more so than before, a residential facility for 'people-with-care'. Nursing home care should therefore be designed for, and together with, residents. If the residents' wishes and desires are the starting point, they should also be allowed to define what quality of care is, instead of this being defined by external standards.

The (quality) managers and directors made the following recommendations to external supervisors for the process of accountability of person-centred care: ask the sector to show what is going well, instead of only having to provide evidence that nothing is going wrong – demonstrate more confidence in the organisations; put dialogue more at the heart of the relationship with organisations; focus dialogue on the process of learning, reflection and improvement; and provide room for customisation and innovation, including in the way accountability is done.

Regarding our method, (quality) managers and directors were particularly enthusiastic about the possibility of reducing the distance between ward and management, about utilizing experiences directly on the work floor and about using experiences as teaching material. In addition, they see opportunities for accountability; for example, providing themes for the dialogue with supervisors or illustrating how learning and development is handled in the organisation. It was indicated that this does require adjustments in the way supervision is carried out; the directors think there will always be a need for numerical indicators.



The perspective of external supervisors

Although it appeared throughout the project that stakeholders consider learning and improvement by staff and accountability to residents much more important than accountability to external supervisors, healthcare organisations should also be accountable to external parties for the care and support provided.

During our project, we presented our method to delegates from the healthcare offices Menzis and Coöperatie VGZ, to the Dutch Healthcare Authority (NZa) and to the Healthcare & Youth Inspectorate (IGJ). The aim was to gather feedback on the method for further development, by finding out what insights the regulators need to get from the experiences to properly assess the quality of care provided.

The interviews revealed that the various supervisors are open to changes in the system of accountability. This applies to both the content (what is accounted for) and the form (when, how and how often). Supervisors indicated that, in new forms of cooperation with healthcare organisations, they want more dialogue and fewer assumptions. Despite the fact that quality managers and directors of our co-creation sessions expressed a keen desire to be held accountable in a narrative manner, supervisors noted that very few healthcare organisations had actually expressed that desire to them.

The IGJ indicated that it wants to assess care organisations primarily on the degree of person-centred care they provide to residents. The IGJ sees opportunities to draw on our findings about working with experiences for this purpose.

The various supervisors indicate that our method provides insight into the process of learning and development and can thus contribute to the dialogue about this. Based on the recorded experiences, healthcare organisations can show supervisors what happens in daily practice, how this is discussed within the organisation, what is learnt from this at various levels and how it is translated into action where necessary. This way of working fits within the vision on accountability as described in the RVS report 'Blijk van vertrouwen' and is also expressed in the Nursing Home Care Quality Framework.

Regarding our methodology, the supervisors had some additional observations:

- avoid making members of staff do things twice – make sure the method either provides additional insights or replaces regular methods;
- ensure that the method fits well with the daily practice of staff, residents and relatives;
- demonstrate that care will improve from using the method, which increases the likelihood of adoption by care organisations;
- help healthcare organisations and supervisors get started on the dialogue so that they strike sound mutual agreements and gather the right information.

To the hairdresser again

The lady was allowed to go to the hairdresser again. So nice! She is really happy with her haircut. She called herself "a beautiful person". These simple things can be so special, especially now with corona.

A nice eggnog

School class

This morning during our care, a class of school-children walked past. My colleague pointed them out to you. As you watch them go by, you say: "Keep walking, you deadbeats!"

3.3 Technical realisation

At the heart of our method is the sharing of experiences by staff, residents and relatives. These experiences are the source material on which learning and development on the ward and in quality policy are based. The way we share these experiences is therefore a key focus. We eventually chose to share experiences via an app on a mobile device, with sharing via a website as an alternative option.

We further developed the existing SenseMaker® system for use by various stakeholders in nursing home care. In this chapter, we discuss the road travelled and what we learnt about the technical realisation of our method.
What we did

- **Setting up the SenseMaker® system** for use in the project, both substantively (experience and interpretation questions introduced), and technically (access for various stakeholders).
- **Introducing the experience-sharing app** to staff, including explaining how to install and use it and providing a smartphone, tablet, and photo printer to use the app.
- **Introduce the dashboard** for viewing and analysing shared experiences among members of staff and (quality) managers and directors.
- **Further developing the system** based on needs and experiences in our project. To collect and process user feedback, we used several methods:
  - Interviews with members of staff about their work routines to see where and how we could connect to this with the system.
  - Design sessions with staff where we got live feedback from users to see where the user interface could be simpler or clearer.
  - Interviews with managers on policy and quality of care to see how we could best set up the dashboard.
  - Guided sessions with (quality) managers and directors on working with experiences, to learn where their information needs are.
  - Deployment of a UX ('user experience') designer to translate the findings from the above activities into a better user experience.
  - Weekly consultation with programmers at Cognitive Edge (makers of SenseMaker®) on adjustments and progress.
- **Realise a link** with the electronic client file (ECD) to also transfer the text of the shared experiences to the files in the ECD (Nedap ONS) used at the organisations.

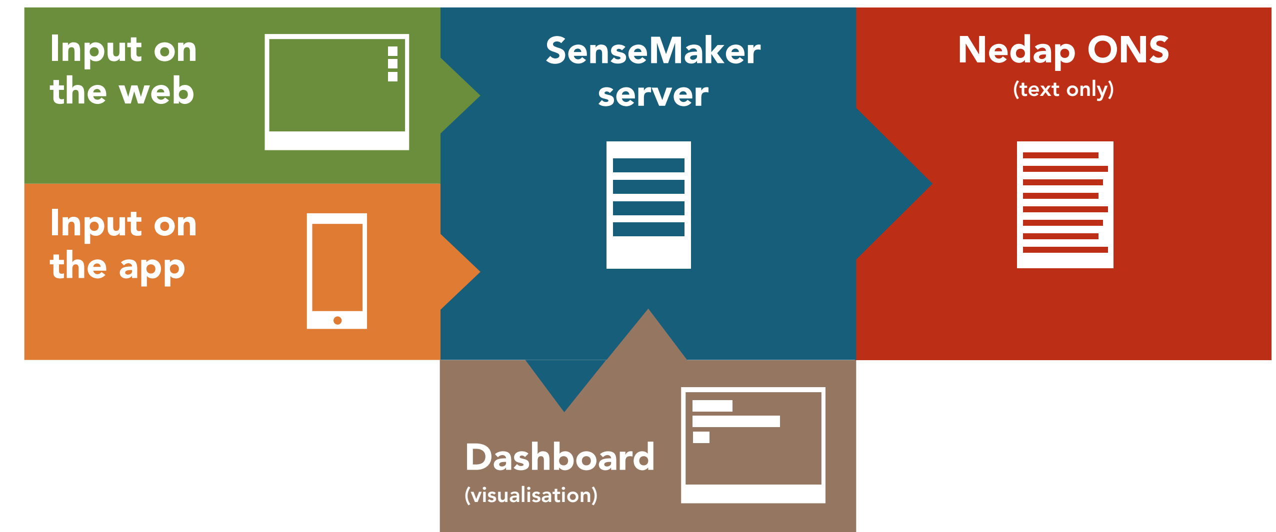
Setting up the system

For our project, it was important that stakeholders:

- be able to share a short experience several times a week, to get the most nuanced picture of the practice and track developments over time;
- be able to share the experiences as soon as possible after the event to minimise colouring by one's own memory and subsequent experiences;
- always able to give meaning to their experiences themselves, to avoid the risk of being coloured by others;
- have the ability to use both text and images.

The SenseMaker® system makes this possible.
In SenseMaker®, storytellers can share their experiences in text and image via an app on a smartphone or via a website and give their own meaning to their shared experience by answering some interpretation questions about their experience. Given our desire to be able to share experiences as quickly as possible, we chose to focus mainly on using the app, with sharing via the internet as an alternative option.

The shared experiences are stored on an external server (in compliance with the GDPR). SenseMaker® is a so-called SaaS solution ('Software as a Service'), which requires no further software installation besides the app. Gaining access to the system happens entirely through the app and the internet. The shared experiences can then be read and analysed via a separate 'dashboard' on a website. To start using the app, we introduced the first set of questions for members of staff and gave them access to the app.
A separate environment with access was set up for both wards.



Introducing the app to members of staff

After these preparatory steps, we were ready to introduce the method and the app to members of staff. This took place during introduction meetings in January and February of 2020. In retrospect, this turned out to be good timing, because not much later, the nursing homes went on lockdown because of the corona pandemic. So, when that happened, staff had already received their instructions and were able to share experiences.

During the introductory meetings, we presented the whole project and allowed staff to practice sharing experiences and answering interpretation questions on paper. Immediately, it became clear that seeing an experience is not something that comes naturally. We also noticed that some interpretation questions were 'difficult' because they prompted reflection from perspectives that were unusual for staff members; a question such as 'whose interest was central to your experience, that of the staff member, the resident or the relative' was found to be difficult because people had not previously thought about the events on the ward in terms of groups with a particular 'interest'.

We started our project with the then available version of the generic SenseMaker® app, which was still partly in English and inconvenient to use. Due to limited access to the internet within healthcare organisations, the app reported frequent failures. These reports made users feel that their experiences had not been recorded, leading to frustration and unnecessary duplication of effort. The app was continuously improved throughout the project (see also the following paragraphs).

In terms of equipment, we gave members of staff a choice: one could use one's own smartphone, one could use a 'work device' or a phone provided by us. At one organisation, Chromebooks (small laptops that only allow website visits) were in use - these devices could also be used for the project; the only drawback was the lack of a camera for taking photos.

During the project, it turned out that members of staff had a desire to also show the photos they had shared in the system to residents. To this end, we provided a photo printer to both wards. The photo printer was much appreciated. Moreover, being able to view experiences in this way contributed to increased awareness and sharing.

> *"Il showed her pictures I had taken of her when she was making a Christmas arrangement. She asked if she could get a print of it. So, I went to print the photo for her on the new photo printer. She really liked it and immediately went to show the photo to her loved one, who was sitting at the table.*
> *The photo printer is already adding value!*
> *Nice to see her looking so happy at a photo of herself and showing it proudly to her loved one.".*
> – Staff member

Once the staff started using the app, a request soon arose to be able to view the shared experiences. This was not immediately feasible because the system was originally created for cross-sectional research, where experiences are collected once and only discussed with respondents at a later stage. To use the system as an electronic diary, however, being able to view experiences on a regular basis was necessary, and therefore this was one of the necessary changes we wanted to realise and test during the project.

Before that, we communicated the shared experiences (and any images) in an offline manner, through newsletters, posters, and a booklet. The booklet proved a great success, as members of staff could now show their experiences to others.

Introduction of the dashboard

In the first months of the project, experiences were mainly shared by members of staff who were supervised by us in doing so (remotely, because of corona). In the meantime, we worked on a dashboard to make the experiences more accessible. Besides being able to view experiences in the dashboard, it is possible to select and analyse experiences in the dashboard using metadata. This functionality is important for going through the quality cycle by (quality) managers and directors.

When we introduced the dashboard to members of staff, they reacted very enthusiastically to the possibility of being able to review their shared experiences. In practice, however, using the dashboard turned out not to be so obvious. The app and dashboard were not integrated, which meant that members of staff had to log into a separate system to see the shared experiences.
This created several barriers:

1. the dashboard proved difficult to access via phone or tablet and had to be used via computer,
2. members of staff lost the link to the dashboard and/or the corresponding login details,
3. the interface was different and a lot less user-friendly than the app.

After several months, when a fair number of experiences had been collected (and it was again possible to meet people in accordance with the corona measures), we invited the (quality) managers and directors of the two care organisations to look at the experiences via the dashboard. Although they were excited about being able to view experiences, it proved difficult for them to grasp the concept of 'experiences plus metadata' directly. They had the inclination to read through experiences chronologically. With about 20 experiences, this is obviously not a problem, but as soon as more than 100 experiences are involved, it becomes impractical. This is precisely when the dashboard's selection options can be used.

People initially struggled with the dashboard user interface. In addition, managers often lacked time to really delve into it. The workload in the sector is already high, but the corona pandemic added to this. During the project, we focused on making the dashboard more accessible and looked at how and with whom in the organisation the analysis of experiences could be invested.

Further development of app and dashboard

With SenseMaker® you can speak of a front end (the app for sharing experiences) and a back end (the dashboard for storing and viewing experiences) of the system. Throughout the project, we worked on both the app and the dashboard, developing them into an increasingly user-friendly and useful system based on user questions and comments.

Involving members of staff

For a long time, because of corona, we had to support staff members one-on-one and by phone on how best to share experiences using the app. This had the advantage of giving us direct feedback on usage. In addition, we interviewed members of staff to better understand at what times in their shift they would be able to share experiences, and in what way they could then most conveniently do so. We also invited members of staff to a design session, in which we were able to see directly how the app and dashboard were being used.

When we involved members of staff it proved difficult to get them to participate in adapting the system to their way of working. This is because most members of staff are used to doing it the other way round: they must adapt to the system. This made it difficult for them to think about how things could be done differently.

In the end, the following areas for improvement emerged, almost all of which have since been realised in the app:

- The app should be fully usable in Dutch.
- The app should allow viewing experiences (so, app and dashboard in one).
- Sharing experiences can be interrupted and picked up again later.
- An experience should also be able to be interpreted later, after sharing.
- The app should remind you to enter an experience at certain times.
- In the app, you should be able to mark experiences for discussion later.
- Experiences in the app should also appear in the ECD.
- The dashboard interface should be simpler for members of staff who mainly want to read stories.

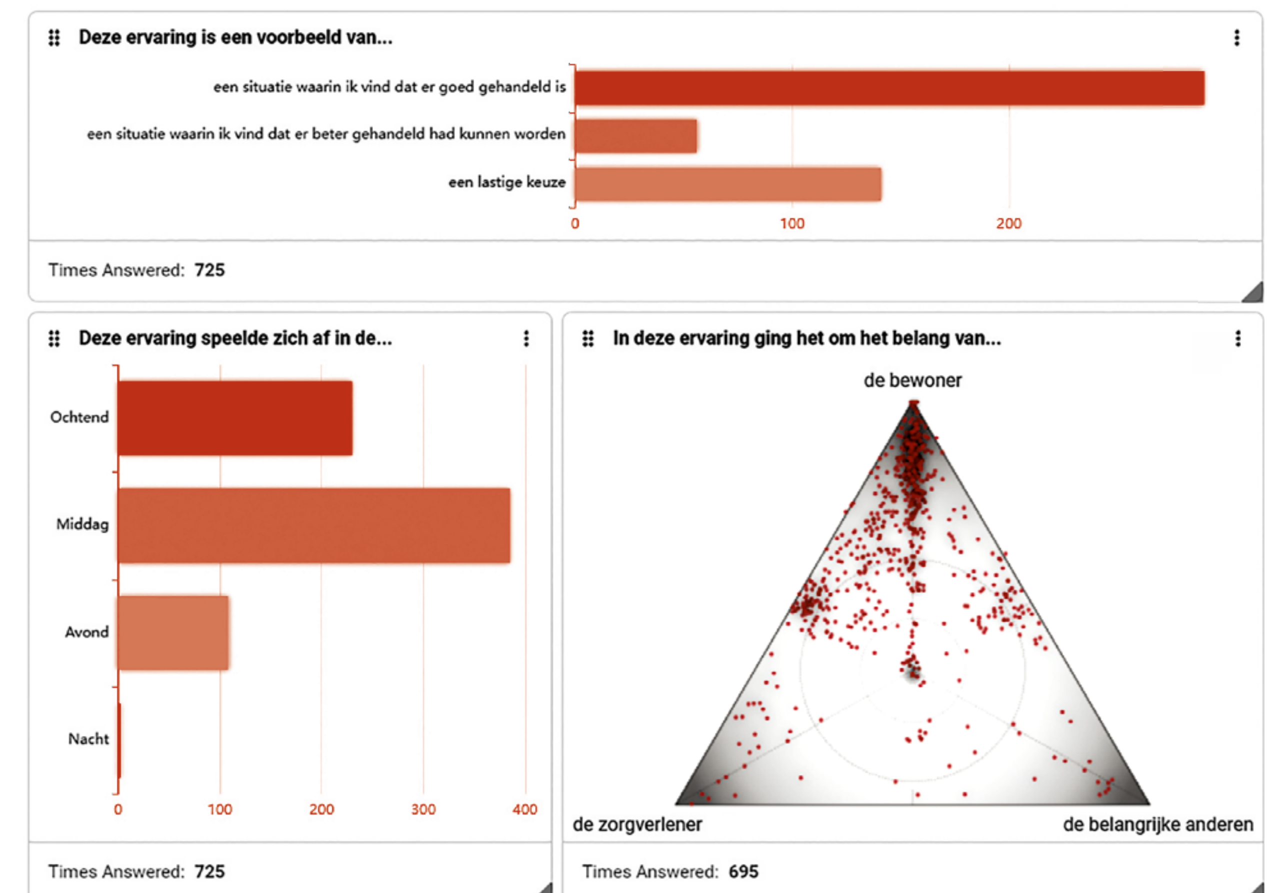
Involving (quality) managers and directors

One of the first steps in involving (quality) managers and directors in our project was the introduction of the dashboard. For most attendees, the Experience Matters method was still quite new and unfamiliar at the time. The team manager and quality manager had knowledge of the app, but they did not often use it themselves.

The version of the dashboard as we used it in the first session was considered quite overwhelming by the attendees. They were enthusiastic about the many features, but the user interface was too complicated.

Apart from the interface and operation, people found it difficult to analyse experiences. Simply reading experiences worked fine and selecting or filtering by a single criterion ('show only experiences that are indicated as a dilemma') was not a problem either.

Example of (a part of) the dashboard



One of the difficulties appeared to be in formulating a targeted question (e.g., 'how were members of staff affected by corona') and then translating that question into an appropriate analysis: if the question was not literally posed as an interpretation question, then it is necessary to be creative with the criteria that are available - in order to select potentially relevant experiences. The question set used was designed before the corona pandemic happened and thus did not include a specific question about corona. What did work in this context was selecting experiences that were mainly about 'rules and protocols', with a 'negative' bias and a role for 'relatives'. By making these selections, several distressing corona experiences immediately appeared.

This way of thinking, and trying things out and analysing results, takes more time and attention than most managers have available. They cannot take on the role of data analyst in addition to their regular job. This strengthens us in the idea of explicitly assigning this task to a different role in the organisation.

The dashboard improvement points defined were:

- The dashboard should be in Dutch.
- The dashboard should adapt to the role of the user: an employee who mainly reads experiences will not want to see all the other features.
- Results of analyses should be able to be stored and shared with others.
- The system itself should be able to spot interesting patterns (no value judgments) to help with analysis.
- It should be easier to juxtapose and compare perspectives from different audiences.

Most of these wishes have now been realised or planned. The functions for signalling patterns or unexpected results are currently in progress but will be increasingly developed in the future. In doing so, it is not the system's intention to assess the content of experiences, because that will always remain a human activity. What the system can do, for instance, is warn if experiences are suddenly interpreted very differently by narrators. It is then up to humans to find out what, if anything, is going on.

The desire to save results of analyses has led to a whole new feature, where information from different places in the system can be posted on an electronic notice board. This also allows for drawing and writing comments. This function is thus not only a valuable addition for saving analyses but can also serve as a record of reflection meetings with members of staff. This allows the process of learning and development to be recorded, making this feature valuable for internal and external accountability.

Deployment of UX designer

Halfway through the project, we added a user interface designer to our team to help make both the app and dashboard more logical and friendly, based on the feedback gathered from users.

The UX designer had further discussions with managers and members of staff to find out what they encountered in using the app. He then organised several design sessions in which we interactively designed a better interface for both the app and the dashboard.

A key part of the UX designer's work involved simplifying the dashboard. This now opens with a 'home page' for each user, showing relevant functions and projects based on one's role. He has also made necessary improvements to presenting experiences themselves. In addition, the UX designer made a major contribution to the noticeboard function, which allows random information from the system to be brought together, commented on, and then shared with others - this function is important for documenting the analyses and outcomes of reflection meetings.

Realising a link to the ECD

Because staff often have to update residents' data in the ECD (electronic client dossier) and normally also enter their observations and reports there, the desire soon arose among staff to be able to transfer experiences from SenseMaker® into the ECD.

Although the experiences shared in SenseMaker® have a very different tone and content from the reports in the ECD, staff soon developed the habit of entering and storing experiences twice: first in SenseMaker® and then in the ECD. This allowed experiences to be shared and reporting requirements to be met at the same time.

Therefore, to avoid duplication or complicated cutting and pasting, staff wanted experiences from SenseMaker® to automatically appear in the ECD as reports. Some members of staff wanted to go a step further by also working the other way round: the ECD would then be leading, with reports being transferred from the ECD to SenseMaker®, to be interpreted there later.

From SenseMaker® to ECD

We started to identify wishes and possibilities for the connection between SenseMaker® and the ECD.
The healthcare organisations participating in our project use Nedap's ONS as their ECD. In this system it is possible to make unstructured notes in text in residents' files, but the use of images, sound files or other information (such as answers to interpretation questions) is not supported. Adapting ONS to our requirements and wishes was not possible; first, ONS is a central system used by hundreds of care organisations, and second, making changes to an ECD was not within the scope of the project.

In practice, this meant that we continued to use the SenseMaker® system as a separate solution alongside the existing ONS, but also started working on linking the two systems in one direction: experiences shared in SenseMaker® should also appear in the ONS file.

Although the technical realisation of this link is not particularly complicated, the coordination and alignment between us, Nedap, the healthcare organisations and SenseMaker® programmers took a lot of time.
The additional delay caused by the corona pandemic meant that while we were able to realise the connection in the test environment during the project, we were unable to bring it into production yet.

From ECD to SenseMaker®

Linking in the other direction, i.e., transferring information from ONS to SenseMaker® was not possible in practice for the limitations mentioned earlier (use of text only, no questions). But even if this could have been done in a simplified form, we probably would not have tried this: we would have mainly preserved the existing way of reporting.

In practice, reporting on residents in ONS is often done retrospectively, and mainly following SOAP guidelines ('Subjective, Objective, Action, Plan'). This produces rather brief and factual texts, which are not comparable to the type of experiences we are looking for in this project.
If this information were used in SenseMaker®, there would no longer be any question of experiences - and thus the approach would then be stripped of its unique characteristics.

The above situation is a diabolical dilemma in innovative projects: if a new system must run alongside the old one, it creates duplication of effort and that demotivates members of staff; especially in a sector like nursing home care where the workload is high. But if the new system adapts too much to the features and limitations of the old system, innovation is hampered, and the conclusion will be that the innovation is of little benefit.

When Experience Matters is deployed for the longer term, it is certainly advisable to further explore the possibilities of integration with current systems; technically this is certainly possible on the SenseMaker® side.

3.4 Impact of corona

The journey of this project is not complete without a description of the impact of the corona pandemic. Soon after the project started in January 2020, the coronavirus made its appearance in the Netherlands. The pandemic had far-reaching consequences for nursing home care and those involved in the wards that participated in our project. In this chapter, we describe the impact of the pandemic on nursing home care and our project.

Impact of corona on nursing home

The Dutch nursing home sector was hit hard during the corona pandemic, both in terms of infections and deaths due to the corona virus. Nursing home staff faced unprecedented challenges during this time. There was much uncertainty about the spread and effects of the new coronavirus, and many staff felt anxious about contracting and spreading the virus. The shortage of personal protective equipment in nursing homes intensified this fear.

Not only the virus itself, but also the associated security measures took their toll in nursing homes. Initially the visit ban and later the rules and restrictions around visits restricted contact between staff, residents and relatives. Residents were kept in isolation when thought to be infected with the coronavirus. Staff were expected to enforce these measures, which led to many dilemmas and conflicts[8].

Impact of corona on the project

Remote contact

For the first two months of the project, we spent several days a week on the participating wards to work with staff to develop our method and guide them in working with experiences. When this was no longer possible due to the ban on visits in the nursing homes in March 2020, we suggested to continue the project remotely. We polled, in one-to-one conversations, to what extent the members of staff were open to this.

Although staff from both wards were concerned about the coronavirus, the teams had varying opinions about the further progress of the project. One team attached importance to continuing to focus on experiences of care and support particularly in this situation and expressed a desire to continue with the project. The other team felt that their attention was needed more urgently elsewhere and expressed a desire to pause their participation in the project.

We tried to listen to both points of view. With one team, we continued and gradually shaped the remote contact together. With the other team, we mutually agreed to continue in August 2020. The coronavirus continued to play a role throughout the project, and it was hard to predict when face-to-face contact would be permitted. This also meant that several group meetings and activities we had planned could not take place or had to take place online. We had to be creative and work around it.

8 Read more about the experiences of two staff members and a relative of a resident with the corona pandemic here:
https://wijencorona.nl/monique52/
https://wijencorona.nl/ana38/
https://wijencorona.nl/wim82/

Visibility of the project in the ward

To keep the project visible and alive during periods of remote contact in the wards, we invested a lot in the relationship and contact with staff (remotely and face-to-face when possible). In doing so, we tried to motivate members of staff to continue with the project by keeping them informed of shared experiences through newsletters, posters, and photo booklets. We also sent reminders when a certain number of experiences was reached. Members of staff reported that these activities were extremely important for (continuing to) share experiences[9].

Contact with target groups

A key premise of our method is that all perspectives within the triangle of staff, residents and relatives are important for shaping and evaluating quality of care. In our project, due to the corona pandemic and associated safety measures, we were mainly able to carry out activities with staff, (quality) managers and administrators. Contact with residents and relatives was difficult at a distance and could often not take place for safety reasons. At those times when contact with residents and the residents' relatives was possible again, we also undertook various activities with these target groups.

Corona vs project

In evaluation interviews held in February and March 2021, staff from both wards indicated that the corona pandemic had hampered the project's progress. On the one hand, there was less focus on the project because the coronavirus and all that came with it took priority. On the other hand, communication between staff and researchers was hampered by remote contact and the inability to continue group meetings.

Members of staff indicated that for both reasons, the project easily faded into the background in their minds. Most staff felt that the project could have matured more had corona not thrown a spanner in the works. Ward staff who wanted to continue the project remotely during the first wave of the corona pandemic indicated that they found the personal contact with the researchers during the corona pandemic supportive. From the second wave on, researchers were even given an employee pass so that they could be present in the ward despite the various measures in place.

9 We wrote a scientific article on the shared experiences of members of staff in corona time: **www.mdpi.com/1660-4601/19/4/2106/htm** or scan the QR code

Passive

The gentleman looks ill, has both his eyes closed and has a runny nose. This morning, he sneezed repeatedly.
I took care of him and prepared his breakfast. However, he does not eat, even if I help him by handing him a bite of the bread. He is very passive and his eyes look dull.
I feel sorry for him and wonder what goes through his mind.

Stopping the shouting

The lady walked through the living room shouting. So I called her over to our table where we were playing a game. The game was to complete the lyrics of old Dutch folk songs.
She spontaneously started singing all of them. Sometimes she made up her own lyrics with a very mischievous look in her eyes. She enjoyed making the others laugh and stayed at the table for the remainder of the activity.
Nice to see that we could stop her shouting behaviour like this.

I want to go home

This morning when I came to see the lady, she was crying in bed. When I asked what was wrong, she said:
"I would like to go home." So, I explained to her that this is not possible, because she can't manage on her own.
I explained she needs help and that's why she is with us.
Now she started to cry even harder because she felt so sorry for us that we had to help her. Because she used to do it all by herself, and now she can't. I spoke with her during morning care and helped her with washing and dressing. When we were almost done, she felt better again. She was happy that I came to help her. I reassured her and told her we love doing it. She understood.
She kept saying she was sorry, but also that she was happy with the care she received. After that, she never brought it up again.

Doing your own thing

The lady doesn't like arranging flowers, but she did join us at the table for the activity. She took a flower and put it in her empty coffee cup. When I complimented her on the nice arrangement, she had to laugh. This is how you can participate in an activity on your own terms. I like it when residents are happy doing their own thing. That's 'enjoying life' for me!

Don't take the easy road

I played a game with the residents who are not the easiest to play a game with. With a lot of patience, instructions and help, we did make it to the end and you could see the residents enjoying themselves.
They do follow the game; they laugh and interact with each other. This gives me satisfaction.

Positivity in a difficult situation

I came in and saw that the condition of a resident, who has just returned to our ward, deteriorated quite a bit during his stay elsewhere. This was painful to see.
After a short conversation he said to me: "But you will always be my friend!"
This touched me, because he had said that he was in pain, and even then he could still say something positive to me.

4. Summary, conclusions, and recommendations

The aim of the 'Narrative Accountability in Practice' project was to develop a methodology for quality improvement and accountability in which working with experiences is part of:
1 the daily practice of staff, residents and relatives;
2 The process of quality improvement and accountability of an entire location and/or organisation.

By working in and together with practitioners on substantive development, organisational implementation, and technical realisation, we developed the Experience Matters method. Based on the road we have travelled and everything we have learnt, we conclude that the experience cycle can be used by staff, residents and relatives to design and evaluate care and support. In addition, the quality cycle enables (quality) managers and directors to use experiences and metadata to evaluate quality policy and use the resulting information for quality improvement and accountability.

According to the various stakeholders, the experiences shared by staff, residents and relatives provide insights and leads for good care and cooperation. In this way, the shared experiences can be used at micro level to jointly design and evaluate good care for individual residents, at meso level to reflect on and improve care and cooperation in the ward, and at a macro level to see how relatively abstract policy goals within locations and/or the organisation take shape and to learn together how things can be done differently.

Substantive development

The substantive development of the method has yielded relevant experience and interpretation questions, which are accessible in a library of interpretation questions[10] for care organisations that want to start working with Experience Matters. The method with specific experience and interpretation questions works particularly well with staff and relatives. It is a dynamic method that suits the process of learning and development in care, which is never finished. For residents with psychogeriatric problems, we experimented with the current and several other methods for mapping their experiences. The aim of these methods was to facilitate residents as much as possible to share their experiences themselves, and if this was not possible, to get as close as possible to the perception of their experiences. In the Activity Book for (quality) managers and directors, we described the steps organisations should take to develop relevant experience and interpretation questions.

Organisational implementation: experience cycle

The organisational implementation of the method provided insights on ways in which staff, residents and relatives can work with experiences in daily practice. In the various activities we undertook with stakeholders, we discovered four phases in using experiences to shape and evaluate care and support: experiencing, sharing, reflecting, and acting. We had a structured collaboration with members of staff over the course of our project. We were in contact with residents and relatives whenever the corona situation allowed it. As a result, the insights gained about the experience cycle among staff were extensive, and the insights about residents and relatives related to specific activities. In the employee Activity Book, we have translated our insights into practical tools to get started with the experience cycle.

Staff

In summary, we learnt the following about the organisational implementation of the method in the daily practice of members of staff:

- Working with the experience cycle requires members of staff to become aware of meaningful moments in everyday actions and events.
- Knowledge of the 'Enjoying Life' approach is a good basis for becoming aware of experiences, but our method also links up with other approaches to person-centred care.
- Going through the cycle of experiencing, sharing, reflecting, and acting requires skills that members of staff can develop.
- Members of staff need support in working with the experience cycle, both individually and collectively (e.g., coaching, exercises, experience tool, guidelines for reflection).
- Members of staff find that the content of experiences better suits the work they do than standard reporting. Experiences provide more information for good care and collaboration than numerical data.
- Staff feel that working with the experience cycle contributes to good care and cooperation. Most staff like the fact that shared experiences allow room for their own emotions.
- Members of staff find that being able to share photos of experiences in our method adds great value. Consequently, they often do so.
- Members of staff mainly use the shared photos and stories in the experience cycle. They are not that interested in the metadata and associated macro-level accountability.
- Members of staff find it very pleasant and useful to get together with their colleagues, exchange experiences and reflect on them together. This had a positive effect on team collaboration.
- Members of staff find it important that the method is used by as many members of their team as possible. This ensures broad support for decisions and puts them in a less vulnerable position ('more experiences' equals 'more anonymity').
- Reflecting on experiences worked well in a short session (30 minutes) between work activities, outside existing moments of consultation and together with a few colleagues.
- Reflecting does not immediately lead to action when members of staff return to daily hustle and bustle and routines. Attention to following up on agreements from the reflection process is needed.
- Members of staff need an incentive to (continue to) work with the experience cycle. Endorsement by an external facilitator, colleagues, (quality) managers and directors, a clear picture of added value, and quick visible results work well.
- Working with the experience cycle requires sufficient time and space.
- Working with the experience cycle contributes to staff members' moral and ethical development.
- Working with experiences brings various tensions between the old and new situation and ways of working. An external facilitator can be helpful to identify these tensions and help teams and organisations deal with them.
- Working with the experience cycle not only contributes to a greater focus on residents' life enjoyment, but also enhances staff job satisfaction.

Residents

In summary, we learnt the following about residents' participation in the experience cycle:

- The stages of the experience cycle are difficult for residents to go through independently, especially for residents with psychogeriatric problems.
- Photos can stimulate residents with psychogeriatric problems in their awareness and sharing of experiences.
- With residents with somatic problems, the use of photos did not work as well, as they often objected to the photos that were taken. They wanted more control over this.
- Staff tend to record residents' experiences without consultation. They think they know the resident's perspective well, want to interpret the resident's voice, find the resident's contribution insufficient and/or have little time to do it together.
- When staff and residents engage in the experience cycle together, it leads to feelings of equality and mutual understanding. By discussing experiences together, residents feel heard and taken seriously.
- Going through the phases of the experience cycle together with residents (by staff and/or relatives) is promising.
- To involve residents in the experience cycle, it is important that organisations know why they want to involve residents, how they want to do it and how it works best for residents.

Relatives

In summary, we learnt the following about the participation of relatives in the experience cycle:

- Although relatives are very keen to get started with the experience cycle, they lack a proper foundation (working in care, knowledge of the Enjoying Life approach) and confidence in their own ability to do this independently.
- Relatives being aware of their experiences can contribute to greater involvement in the care of residents.
- Joint sharing of experiences with relatives (by someone from outside the team) works well. On the one hand, because relatives like to tell their stories, and on the other, because they need support in becoming aware of and sharing experiences.
- The experiences shared by relatives are more often about the physical care of their relatives than about their well-being.
- Although staff and relatives are curious about each other's experiences and both wish to improve the relationship between them by sharing experiences, it also creates tensions.
- The technological solution of our method should not replace the conversation between members of staff and relatives, but rather be used to facilitate the conversation between members of staff and relatives.
- When involving relatives in the experience cycle it is important that organisations know why they want to involve relatives, how they want to do this and how it works best for relatives.

10 The interpretation question library can be accessed at **www.leefplezierindezorg.nl/duidingsvragenbibliotheek** or scan the QR code

Organisational implementation: quality cycle

In the organisational integration of the use of experiences for quality policy and accountability, we discovered that (quality) managers and directors go through four phases: drawing up a quality plan, formulating interpretation questions, applying methods, and formulating insights. In the project, we mainly went through the 'applying the method' phase with them, in which they analysed experiences and metadata and tried to make the connection with the experience cycle. Although (quality) managers and directors are convinced of the added value of our method, they are still searching for the best way to embed the quality cycle in the organisation. In the Activity Book, we share practical tools to get started with the quality cycle.

In summary, we learnt the following about the organisational incorporation of the quality cycle in the work of (quality) managers and directors:

- (Quality) managers and directors find that working with the quality cycle provides insight into what is happening in the wards.
- Reading shared experiences captures the imagination of (quality) managers and directors. Analysing by using metadata less so. Support in this is important.
- Working with the quality cycle takes more time than current processes to map quality of care. On the other hand, the quality cycle and connection to the experience cycle provides a lot more information than the current processes and this information can be used for both monitoring and learning and development.
- Reflecting on experiences together reduces the distance between the ward and management and policy and practice, both in perception and language.
- The (quality) managers and directors see working with Experience Matters as part of a larger transition to a learning organisation. Besides introducing the method, processes to improve quality and accountability also need to be adapted.
- Placing the method with one key person or core team in the organisation and/or location (aka motivator) is important for the organisational implementation of Experience Matters.
- Many (quality) managers and directors outside our project are especially enthusiastic about internal quality improvement and accountability through the use of narrative.
- Managers and directors outside our project feel that accountability, trust, dialogue, learning, reflection, improvement and customisation should be key points.
- Supervisors are open to changes to the system of accountability (both in content and form) and are working on 'reflexive supervision'.
- Experience Matters can make a positive contribution to the shift from 'normative supervision ' to 'reflexive supervision' being made by the IGJ.

Technical realisation

In the technical realisation of Experience Matters, we further developed the existing SenseMaker® system for use by various stakeholders in nursing home care. In doing so, we started at the foundation: the system morphed from its original function as an instrument for cross-sectional research into an electronic diary that supports staff, residents, relatives, (quality) managers and administrators in quality improvement and accountability. By working on the development of our method in practice, users also went through a development at the same time: from incidental and small-scale mapping of stories about personal experiences of care and support to working with experiences on a daily basis and using them as part of the process of quality improvement and accountability. Our approach, in which we collaborated with the various users, with Cognitive Edge developers and a UX designer, resulted in a much improved SenseMaker® app with a dashboard that better matches the wants, needs and capabilities of stakeholders in nursing home care.

Recommendations for implementation

- Support among members of staff – ensure support for the method among members of staff and shape the process of implementation and execution with them.
- Staff support – ensure adequate support for staff when working with the experience cycle. Both for developing individual skills, and for properly using the method in teams.
- Motivate and stimulate – motivate and stimulate members of staff in different ways. Include support and motivation from an external facilitator and by colleagues and provide a clear picture of the added value of the method and insight into the results.
- Employ a facilitator – use an external facilitator as a constant reminder, motivation and support. The facilitator motivates, encourages, offers personal guidance and is approachable for questions.
- Involving residents and relatives – as an organisation, create a vision for involving residents and relatives in the experience cycle. Design the process in a way that allows them to contribute and that ensures that something is done with their input.
- Collaboration – above all, let the various stakeholders work together on Experience Matters. The best results come from staff, residents, relatives, (quality) managers and administrators discussing experiences together.
- Time and space – provide sufficient time and room for those involved to work with Experience Matters, get acquainted with the method and learn and develop using
- the method. Those involved should not see the method as 'yet another task'.
- Prevent unnecessary workload – when members of staff start working with Experience Matters, it is important to prevent as much unnecessary work as possible. Think about what members of staff will no longer be doing and make choices for recording information.
- Deploy from vision – use Experience Matters (or other methods for narrative quality improvement and accountability) because it aligns with the organisation's vision and how members of staff want to work. Do not see it as just a 'chore' that needs to be completed; it is a means, not an end.
- Investigate motivator role – delegate the method to one key person or core team in the organisation and/or location. There must be an 'owner' of the method within the organisation and/or location. If it belongs to everyone, it belongs to no one and then it is likely to be abandoned.
- Support from management and board – working with Experience Matters is more than just introducing a method. It is a transition that the whole organisation goes through. Management and board must get behind it and act accordingly.
- Part of a larger transition – deploy Experience Matters as part of a larger transition to a learning organisation. Besides introducing the method, the processes to improve quality and accountability also need to be adapted.
- Experience Matters = innovation – when introducing the method, be careful not to integrate too much of what was already there. When you consider the method an innovation, it will make the greatest contribution to a learning organisation.

5. Ervaringen Centraal in breder perspectief

On the road we have travelled in these recent years, we noted that experience-based working is consistent with three interrelated transitions currently underway within nursing home care:

- The transition from needs-based care to person-centred care.
- The transition from implementing protocols to learning and development.
- The transition from normative supervision to reflexive supervision.

In this chapter, we briefly describe how Experience Matters connects to these transitions and the opportunities and possibilities offered by working with experiences.

Transition from needs-based care to person-centred care

In the last century, Dutch nursing home care was professionalised. This brought many positive benefits: accessibility of care, equal treatment, and care for vulnerable elderly people. At the same time, practices and rules made their appearance in care. Protocols, checklists, and registrations around needs-based care became commonplace.

> *"Sometimes I see my staff in those white uniforms and I feel like I'm at the hospital. But in my opinion, a care home should feel like a community; a big family where we try to make that difficult last period of life as pleasant as possible."*
> – Director of Care Organisation

There has been a change during the last few decades. There is an increasing focus on person-centred care, in which the wishes and desires of residents are central. In nursing home care, staff, residents and relatives play an important role in shaping and evaluating person-centred care. The starting point is that residents and their relatives should be allowed to say what they feel quality care is, and that the organisation (and staff) should think about whether and how to achieve it.

This means that person-centred care is also about expectation management: the ideas that residents and relatives have about quality of care do not always match the ideas that staff and managers of healthcare organisations have about it. This can lead to misunderstanding, frustration and dilemmas. The best remedy for this is to align expectations by providing insight into each other's perspectives and engaging in dialogue.

A method like Experience Matters can be supportive of this in several ways. At a time of increasing staff shortages, it is important to involve relatives more in care. During our project, we found that sharing experiences can play a role in creating mutual understanding of the challenges that staff, residents and relatives face together. For example, staff are not always aware of the feelings of relatives and relatives sometimes do not understand the choices made by members of staff. Talking about concrete experiences facilitates dialogue about expectations and frustrations - provided the process is carefully managed.

Transition from implementing protocols to learning and development

Quality of care arises from within, in the relationships within the triangle of staff, residents and relatives. Doing the right thing for residents and dealing with dilemmas cannot be captured in data or rules. The transition to more person-centred care therefore entails exchanging working with rules and protocols for flexibility and reflection: the focus shifts from *what* is done to *why* and *how* something is done. At the same time, the Nursing Home Care Quality Framework calls for more attention to autonomy, compassion, uniqueness, and collaborative decision-making. These are broad, abstract concepts that can be translated to the work floor in many ways.

Considering these developments, continuous learning and development by reflecting on one's own actions is a *must*. A method like Experience Matters is ideally suited to this way of working. Through context-rich information retrieved directly from practice, the members of staff, (quality) managers and directors become more aware of what is happening in the ward. Qualitative methods also offer more concrete tools for change.

Of course, Experience Matters is not the only method for narrative quality improvement and accountability. Leyden Academy is part of a network of knowledge institutes in the Netherlands, all researching the use of stories for evaluating the quality of care [11].

Transition from normative supervision to reflexive supervision

Person-centred care focusses on the relationship and dialogue within the triangle of staff, residents and relatives. This relationship and the way communication and accountability function within this relationship, could serve as an example for how healthcare organisations and supervisors interact. A possible objective could be to deal with each other on an equal level. And that the information that the care organisation shares with the care administration office and other supervisors is mainly about 'sharing' rather than 'being held accountable for'.

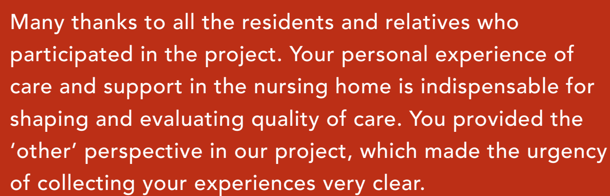
This is precisely the turnaround that, for example, the Healthcare and Youth Inspectorate (IGJ) intend to make: from normative supervision to reflexive supervision. Instead of checking for norms being exceeded, it wants to move towards a form of supervision where inspectors engage in conversations about dilemmas. This includes more room for context, for uncertainty and for own initiative. After all, doing the right thing for a client is more about a certain (learning) attitude among managers and staff than about following strict protocols and guidelines.

A method like Experience Matters can play an important role in this reflexive supervision as a source of concrete, context-rich cases. Engaging in dialogue is easier if material is available for a longer period of time and if records show how dilemmas were discussed and how they were subsequently acted upon. Narrative information is not only appropriate to account for dialogical processes, but in this way also provides a basis for a dialogical process of accountability.

11 More information on the network can be found at **www.linkedin.com/groups/12585696/** or scan the QR code

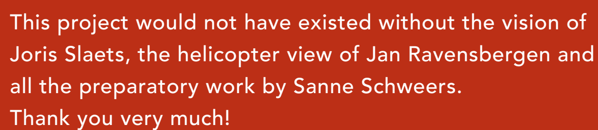
Acknowledgements

First and foremost, a warm thank you goes out to all the staff at De Den and Madelief who helped us time and again in making our project a success. You all shared countless experiences, small and big, happy and sad, inside and outside of your comfort zone and everything in between. You showed your vulnerability in reflecting with each other and us on everything you experienced, while always striving to ensure good care for the residents. By working together with you, we were able to develop a method that allows experiences to occupy an important place in our daily work. We learnt a lot from you and enjoyed the beautiful, important, and sometimes tough work that you do.



Many thanks to all the residents and relatives who participated in the project. Your personal experience of care and support in the nursing home is indispensable for shaping and evaluating quality of care. You provided the 'other' perspective in our project, which made the urgency of collecting your experiences very clear.

Finally, we would like to thank all managers and directors of Respect and ZZG Zorggroep for their efforts in developing our method. Your enthusiasm about the use of narrative information for quality improvement and accountability was palpable.



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