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Lessons Learned and Implications of Function Focused Care based Programs of Various Nursing Care Settings: A Thematic Synthesis

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Abstract

Background and Objective: Function-Focused Care (FFC) aims to optimize daily functioning of older people by changing clinical nursing practice of care professionals. Recently, three multicomponent FFC-programs were implemented in the Dutch home, nursing home, and hospital care setting. Process evaluations were conducted including eight focus groups with 45 care professionals and one focus group with 8 involved researchers. The objective was to synthesize findings and provide lessons learned and implications to optimize future programs.

Methods: A thematic synthesis was conducted of nine focus groups using the COREQ checklist. Deductive coding analysis was applied using Nvivo Software.

Results: Six themes emerged from the focus groups: four related to those components to be preserved in future programs (policy and environment, education, goal setting, and coaching), and two related to the impact of FFC-programs, and its facilitators and barriers in practice. FFC-related policy and a facilitating environment were considered prerequisites to successfully implement FFC. Education sessions could be improved by being more interactive, containing sufficient behavior change components, and tailoring its content to participants' needs. Goal setting was poorly delivered and should receive more attention in practice. Coaching was considered pivotal to consolidate FFC in practice.

Conclusions and relevance to clinical practice: We suggest to develop an advanced FFC-program for various care settings, which allows for tailoring to setting-specific elements and requirements of participants. Lessons learned include addressing all FFC-components jointly, including a comprehensive interactive educational component that primarily focusses on behavior change in care professionals. Managers should support FFC in practice by ensuring sufficient time and staff resources.

Keywords: Function focused care; Activities of daily living; Independence; Care professionals; Education; Tailoring; Behavior change

Abbreviations

FFC: Function Focused Care; ADL: Activities of Daily Living; CP: Care Professional; SAAH: Stay Active at Home; DN: Daily Nurse; FFCiH: Function Focused Care in Hospital; COREQ: Criteria for Reporting Qualitative Research

Introduction

Many Western countries, including the Netherlands, deal with an aging population. In the Netherlands, it is expected that compared to other age groups, the number of people aged 65 and over will increase most by 2060 and will account for one fourth of the total population composition [1]. Due to aging or related conditions, people are at risk for functional decline and care dependency [2]. Consequently, many people reach a point where they require formal care to complete tasks fundamental to daily life. In the Netherlands, this formal care is generally provided by nursing staff throughout the entire care continuum, i.e. at home, in nursing homes or in acute care [3,4]. For instance, support may be required in activities of daily living (ADL) such as personal hygiene and dressing, toileting, mobility, and eating and drinking [5,6]. Given their direct and frequent contact to those in need of care, nurses are in an ideal position to motivate and enable older people to optimize their daily functioning and independence.

Optimizing the daily functioning and independence of older people fits the ongoing shift from the traditional medical care model towards a social care model focusing on person-centeredness and capabilities [7]. The social care model puts an emphasis on people's needs, autonomy and independence, which is highly desired by older people and considered essential to enhance personal well-being and quality of life [8-10]. Generally, nurses do acknowledge an active role for themselves in promoting activity, perceive they have sufficient

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knowledge and recognize the benefits of the social care approach, not only for their clients but also for themselves [11,12]. However, still many nurses conceptualize their role as task-oriented and tend to - well-intended - take over tasks from clients [13]. This may result in deprivation of older people's remaining abilities, further functional decline and finally disability [14-16]. In daily practice, various barriers seem to impede nurses to adequately support and enable older people to optimize their daily functioning [11,17]. For example, barriers may occur at the level of the client (e.g. lack of knowledge), the care worker (e.g. lack of skills), the environment (e.g. narrow hallways), and the organization (e.g. lack of policy and support) [11,12,18]. Clearly, nurses need support to successfully pursue the principles of the social care approach in practice.

Care philosophies like Function-Focused Care (FFC) and equivalents such as Reablement and Restorative Care aim to support nurses to deliver care according to the principles of the social care model. Generally, these philosophies are holistic in nature and comprise multiple components such as policy, an environment check, education, goal setting and coaching. These philosophies have guided the development of numerous (inter)national programs for various care settings [14,16,19]. In general, such programs have shown to be feasible in practice but have demonstrated mixed results regarding their effectiveness in improving care professionals' FFC-enhancing behavior, and clients' engagement in physical and functional activity [20-23]. To optimize future programs and with that the daily functioning of older people, thorough evaluations of FFC-programs are therefore suggested [24].

Based on the aforementioned care philosophies, recently three programs were developed, implemented and evaluated in Dutch home care 'Stay Active at Home' (SAAH), nursing home care 'Daily Nurse' (DN), and acute care 'FFC in Hospital' (FFCiH) [25-27]. This process was guided by the Medical Research Council-framework for complex interventions [28]. Following the development, pilot studies were conducted to assess programs' feasibility and acceptability, and consecutively its (cost)-effectiveness has been tested in separate trials. Parallel to these trials, process evaluations were conducted including focus-group interviews with care professionals who participated in the programs, i.e. mainly nurses. These interviews aimed to explore nurses' perceptions on how the care philosophies and its components were addressed in their daily care, and to identify facilitators and barriers regarding their implementation.

The current Dutch FFC-programs, but also those developed in an international context, differ markedly in their structure, content, delivery strategy, and design, while their aim across countries and various nursing care settings is similar. This not only impedes clear comparisons between programs, but also hinders the identification of which components are valuable and should be preserved [24]. To address the uniformity and to optimize future programs, synthesizing the findings from the separate focus groups may yield insight in those program components that should be preserved in future programs and common facilitators and barriers across nursing care settings. Moreover, because FFC-programs respond to a topic that is relevant in all nursing care settings, such a synthesis may provide valuable lessons learned and implications for developing an advanced generic FFC-program, to be applicable in various care settings. Therefore, the aim of the current study was to thematically synthesize the findings from the focus group interviews conducted as part of the process evaluations in the Dutch FFC-studies. The available data was supplemented with a newly conducted focus group with researchers involved in the development, implementation and evaluation of the Dutch FFC-programs. Adding the perspective of researchers can provide insight into their vision of valuable components, facilitators and barriers, and clarify whether this is in line with the vision of those who participated in the programs. The results can be used as a starting point for an advanced generic FFC-program applicable to a variety of nursing care settings.

Materials and Methods

Design

A thematic synthesis was carried out in which we combined the findings from previously conducted focus groups with program participants with a newly conducted focus group with researchers [25-27]. According to Dutch regulation, no specific ethical approval was needed for this study according to the rules of the Medical Research Involving Human Subjects act (WMO) [29]. For the report of qualitative research, the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist was applied.

Data collection and participants

In total, data from nine focus groups were used; data from eight previously conducted focus groups with care professionals who participated in the three Dutch FFC-programs, and data from one newly conducted focus group with researchers involved in those programs.

The focus groups with care professionals were conducted after the completion of the concerning trial. For 'SAAH', two focus groups were conducted in November 2018; one with nursing staff and one with domestic support workers. For 'DN', two focus groups with nursing staff were conducted between July and September 2017. For 'FFC in Hospital', four focus groups with nursing staff were conducted between October 2016 and October 2017; two from neurologic wards and two from geriatric wards. The inclusion criterion was that participants had to be a care professional who had (partly) participated in the concerned FFC-program. After completion of the concerned program, care professionals were invited to participate in a focus group at their workplace and focus groups were guided by researchers involved in the specific trials. Transcripts of these eight previously conducted focus groups were made available for data analysis in the current study.

The focus group with researchers was conducted after the completion of all separate trials in March 2019 and was guided by researcher and author MH. The inclusion criterion was that researchers were involved in the process of developing, implementing and evaluating either of the separate Dutch FFC-programs. All nine focus groups were semi-structured using a brief pre-arranged topic guide. Topics included 1) the implementation of and experiences with the programs and its components, i.e. policy and environment, education, goal setting and job coaching, 2) the perceived outcomes of the programs, and 3) the perceived facilitators and barriers of implementing FFC in practice. The aims of all focus groups were of similar nature and included getting insight in those program components that should be preserved in future programs, and

common facilitators and barriers of implementing FFC across nursing care settings. In addition, the focus groups aimed to draw valuable lessons and implications for developing an advanced generic FFC-program, applicable to a variety of nursing care settings. All interviewees, i.e. care professionals and researchers, were requested verbal and written consent to participate and audio record the interview prior to its start. Baseline characteristics collected from participants included gender, age, function and care setting.

Data-analysis

Sample characteristics of the interviewees were described using frequencies in SPSS Software. All nine interview transcripts were analyzed using Nvivo 12 Software. Deductive coding analysis was performed by authors MH, WdL, SV and a student assistant taking into account the stages of conducting a thematic synthesis in qualitative research [30]. First, authors MH and WdL prepared a concept-coding tree by closely reading through the transcripts and highlighting and coding relevant text segments. Inconsistencies were discussed and agreed upon resulting in a final coding tree. Next, all transcripts were closely read through and discussed again, now among SV and the student assistant. Using the final coding tree prepared by MH and WdL, SV and the student assistant then independently coded a single randomly selected focus group interview after which coding inconsistencies were discussed and agreed upon among the latter two. Within this stage, relevant text segments were grouped under descriptive themes from the final coding tree. Subsequently, the same process was repeated for the remaining focus-group interviews. In this latter phase of coding, inconsistencies were discussed and agreed upon among SV and the student assistant, with intervention of MH to ensure coding consistency. The final stage of the thematic synthesis was to generate analytic themes, in which researchers discussed and interpreted the findings, and formulated implications for future research and practice.

Results

Sample characteristics

Table 1 shows the characteristics of the participants in the 9 focus-groups. In total, 8 researchers and 45 care professionals, mainly nurses, consented to participate in the focus groups. Most researchers were female (n=7, 88%), aged between 30-50 years old, and involved in research conducted in long-term care. Of the 45 care professionals (CPs), 17 (38%) were from home care: 10 nurses and 7 domestic support workers (DSWs), of which most were aged between 30-50 years old. Twelve (27%) were from institutionalized care: 9 nurses and three allied CPs, of which the age was distributed fairly equally. Sixteen (35%) were from acute care: 12 nurses, 2 student nurses, and 2 care assistants, of which most were aged below 30 years old. In all care settings, most CPs were female (n=41, 91%).

Interview Themes

Six descriptive themes were derived from the interviews. Four themes related to those program components that should be preserved in future programs, i.e. policy and environment, education, goal setting, coaching. The other two themes included the perceived impact of FFC-based approaches, and facilitators and barriers of applying FFC-based approaches in daily practice.

Policy and environment

Organizational policy regarding the stimulation of physical and functional activity was considered a prerequisite to successfully implement FFC.

We believe that the organization should have a policy aimed at stimulating activity. Being more specific, the policy should be aimed at stimulating activities of daily living in clients. That should be a justification from the management towards the nursing care staff so that they feel their support. [RESEARCHER_DN]

Although organizational policy was believed to be supportive of FFC, this was not actively communicated or visible within organizations, which was seen as a barrier.

You [as a manager] should not only mention that [the organization] has a policy and that we should read it, you can also explain what the scope of the policy aimed at physical activity is. [NURSE_DN]

Broad support for FFC within all layers of the organization was considered an equal prerequisite as organizational policy. Particularly, the direct management of CPs should favor FFC and support their staff in terms of providing clear and timely information about e.g. FFC-related trainings, sufficient time, staff members and autonomy to carry out FFC, and supporting tools to implement FFC adequately. Moreover, managers were preferred to take part in the educational sessions, to deal with potential resistance to FFC in practice, to monitor the progress of FFC, and to be involved in the implementation of FFC. Uninvolved and uncommitted managers were viewed as hindering factors.

According to researchers and CPs, the physical environment should facilitate the implementation of FFC. In home care, the environment was believed to be subject to continuous change and a responsibility of the client. However, in nursing homes and hospitals the environment was viewed as a rather fixed component where the organization should take responsibility in its facilitation for FFC.

That is a notable difference between the home care study and the hospital study… the environment in which a patient finds himself is always different in the home environment and stable in the hospital environment [RESEARCHER_FFCiH].

Researchers and CPs from all settings agreed that a thorough and continuous evaluation of the environment and optimizing the environment accordingly should be part of the implementation of FFC. Further, many researchers viewed obstructive building constructions, to narrow rooms, and the inability to make environmental changes as practical barriers. Although the environment was generally perceived among interviewees as an important component of FFC, it received relatively little attention in home care, no attention in nursing homes, and moderate attention in the hospital program.

Education

Most researchers and CPs were of opinion that a nurse with experience in healthcare should guide the educational component, and that all team members should be educated.

I think a success factor is that you educate as many people as possible. Because if it is only a small group, you cannot address something, because the other half has not taken part. [RESEARCHER_

DN]

It would be nice if everyone on the team would participate, so everyone understands what you are talking about, because sometimes they will look at you like 'I haven't heard that before'. [DSW_SAAH]

CPs preferred a multidisciplinary involvement in the education given the valuable interaction and input from different angles. For example, CPs in homecare valued the exchange of information with domestic support workers. CPs also preferred adequate and timely information about the onset of the educational sessions - which was not always perceived as such in current programs – for example by a short video or by discussing the education in team meetings. An information letter and session for clients and relatives was highly recommended to explain the rational and course of events related to FFC. Within the educational sessions for CPs, an interactive and practical approach was favored in which participants could exchange experiences and learn mutually, rather than the generally school-based approach in the current programs. Researchers indicated that the education should primarily focus on creating awareness for FFC in CPs, however, subsequently tools should be offered to CPs themselves to generate awareness for FFC in clients.

You want to achieve two things: first to create awareness in the care worker, and second to provide them with tools to generate awareness in the client. [RESEARCHER_SAAH]

Some researchers and CPs mentioned that the content of the educational component should be tailored to the current level of FFC provided in practice, the knowledge of CPs of FFC, and the setting FFC was to be carried out in.

I would properly explore what the ward is already doing [with regard to FFC] and adapt to that. [NURSE_FFCiH]

The educational components across all programs started with explaining the rationale and advantages of FFC and raising awareness of its importance. Subsequent sessions focused on how to optimize client's daily functioning and independence, e.g. by setting goals or discussing behavior change phases. Researchers agreed that the educational sessions should ultimately result in a mindset change and intrinsic motivation in CPs to implement FFC. Raising awareness proved a key element of the education, however, researchers emphasized to incorporate more behavior change components to address the intrinsic motivation and mindset of CPs, but also to change behavior in clients.

The question is, how we apply those programs, do they really focus on changing behavior? Or should we add an additional component - I don't know how to do that – but that we put effort in the behavior change process? [RESEARCHER_DN]

Topics within the educational sessions that were highly valued included conversation techniques, creating consistency within teams, giving and receiving feedback, and tips and tricks on how to stimulate clients by making use of client cases. An actor-guided role-play session to practice skills, employed only in the home care program, was highly valued by most CPs. There was a debate among researchers whether to focus on one or all care interactions in the educational sessions. However, in nursing homes where the focus was on a single component of ADL care, an assumed spin-off effect to other care activities was not observed. Most CPs therefore preferred to focus on a broad spectrum of ADL.

Table 1: Sample characteristics interviewees.

	N (%)
Researcher characteristics (N=8)	
Gender	
Female	7 (88%)
Age	
<30	1 (12%)
30-50	7 (88%)
Care Setting	
Home care	1 (13%)
Institutionalized care	4 (50%)
Acute care	2 (25%)
Various	1 (13%)
Care professionals' characteristics (N=45)	
Gender	
Female	41 (91%)
Age	
<30	11 (24%)
30-50	14 (31%)
>50	17 (38%)
Unknown	3 (7%)
Function	
Nurses	31 (69%)
Nurse student	2 (4%)
Care assistant	2 (4%)
Domestic support worker	7 (15%)
Allied CPs[a]	3 (7%)
Care Setting	
Home care	17 (38%)
Institutionalized care	12 (27%)
Acute care	16 (35%)

[a]Physiotherapist, occupational therapist, activities coach.

Goal-setting

In all programs, goal setting was part of the educational component where CPs learned how to set short- and long-term FFC-goals and compile action plans. However, in practice, CPs did not explicitly set goals. Frequently cited reasons for this by both researchers and CPs included time pressure, forgetting, setting goals not being a habit, and difficulty with involving the client in the goal-setting process. More often, goals were set implicitly, thereby taking into account the day-to-day varying needs and capacities of clients. Several factors were regarded as facilitating the goal-setting process. These entailed setting goals for clients individually as well as setting goals at the CP-level about how they intended to deliver care. In general, the reporting of goals was viewed as a pivotal step in the goal-setting process.

It is just like with setting goals, you will maybe do it in your head but you have to report it in a file, evaluate [it], and consciously deal

with it [NURSE_FFCiH].

Some CPs who participated in the home care or hospital program indicated that reporting goals served as a reminder to carry out the goals, as a cue to colleagues to build on a previous goal, to facilitate consistency within teams, and to monitor the client's progress. However, in practice, set goals were often not reported, while if reported, goals were frequently not up-to-date. Taking time to set goals, discussing the goals with clients and providing them ownership, and involving relatives and other care disciplines in the process were also considered to facilitate goal setting. A combination of short- and long-term goals was preferred; in most settings a series of key long-term goals were favored by clients, such as staying at home as long as possible, rehabilitation from hospital, or maintaining their physical condition.

You have to take the time together with your patient: what do you want to achieve today and what in long-term? And that will take time, because they will think: 'well, what do I want to achieve?' And then you start talking to the patient: 'where are you from, what do you like to do when you are at home?' [Client]: 'working in the garden.' Well, that is a long-term goal for which you can then set short-term goals. If you have to do that for four patients, it will take you a lot of precious time [NURSE_FFCiH].

Coaching

The coaching component was shaped differently in all programs. In home care, coaching received moderate attention in terms of role-play games during the educational component. This because practical coaching proved difficult as CPs visit their clients individually and direct contact between CPs rarely occurs. In the nursing homes and the hospital, several CPs were appointed as a coach; those who volunteered and were enthusiastic and self-confident were considered ideal for the position. The preferred way to shape coaching was to discuss client cases in team meetings, periodically put FFC and coaching on the agenda, one-on-one supervision, walking rounds together, giving each other feedback, and having a point of contact.

You keep on discussing it within the team, how to deal with this client case, how do others approach this. It quickly deludes because of the time pressure; many people want to do it quickly because they have no time… but you should keep paying attention to it, maybe in a team meeting, a fixed agenda item, so it stays in the spotlight. [NURSE_SAAH]

Particularly in the hospital program, coaching received major attention and was considered essential to consolidate the knowledge and tools obtained from the education in practice. Factors put forward by CPs to hinder successful coaching were having insufficient time or too little time together with colleagues to discuss FFC. Some researchers mentioned that making a CP person responsible for coaching made others feel less responsible to implement FFC and that this increased the chance of dilution of FFC.

Perceived impact of function focused care

Both CPs and researchers stated that the different programs mainly raised awareness, which manifested in that CPs realized that they could work according to the principles of FFC rather than automatically take over tasks from clients. Awareness was also raised in terms of increased knowledge about the benefits and importance of FFC for the client, such as maintaining functioning and autonomy.

I became more aware, which I think is very important. I occasionally applied the FFC principles, but now I am much more aware of it. But sometimes it's difficult, on the one hand it saves time, but on the other hand it often takes time [NURSE_FFCiH].

Last, the FFC-based programs served as a revelation to some CPs in that they realized they were practicing FFC to a lesser extent than initially thought, while still many reported that stimulating their clients was no different from how they currently worked. Rarely mentioned practical benefits of the programs entailed: improved communication and collaboration with clients and among colleagues, greater consistency within teams, FFC being time saving, higher work satisfaction, self-confidence, creativity and autonomy, and improved confidence and self-esteem of clients.

Although CPs indicated a change in awareness and despite some changes towards FFC were observed in practice, researchers generally believed that a change in mindset in CPs was not achieved.

You could say that an intended mindset change was not fully achieved. We observed changes in setting goals, but still not optimal. We saw that if they [care professionals] had an external trigger, that they thought: 'oh indeed, function focused care!' So they really need an external stimulus to do it… not based on the philosophy [RESEARCHER_FFCiH].

Frequently mentioned perceptions justifying that FFC was not fully adopted in practice related to time investment of CPs to implement FFC as it seemed that CPs were unwilling to invest time now to motivate and stimulate clients, to potentially safe time in the future.

That is what I mean with short-term thinking, because we think like 'we do not have time now', but in long-term [clients] will not benefit if we keep taking over [tasks]. [NURSE_SAAH]

Facilitators and barriers of function focused care in practice

Perceived facilitators and barriers of FFC in practice varied among care professionals, organizations and clients.

Care professional facilitators: According to CPs, facilitating factors for FFC in practice entailed explaining the benefits of FFC and disadvantages of inactivity to clients, involving clients and discussing key long-term goals, expressing mutual expectations, and tailoring FFC to the client's capacity. Other facilitating factors comprised of taking sufficient time, setting achievable goals, and the ability of CPs to cope with busy working conditions.

In between, I often do something else, while I am close to the patient. Shaving for example. When I am making the bed I give the shaver to the person and I will let the person shave him/herself, and you can just say 'well, you should do it like this, or you should still do the bottom [of your chin], let me do that'. However, I will not sit next to it quietly; I try to do something else in between, because otherwise it will take too much time. [NURSE_FFCiH]

CPs from various care settings identified convincing clients with jokes, using visual or verbal cues, giving hints or instructions, stretching activity time, spawning and negotiating, and enabling

relatives to implement FFC as promising strategies to pursue FFC. Last, letting clients first complete tasks themselves and if necessary repeating the task, was viewed as a promising strategy.

So you should let the people do it themselves, but sometimes you have to do it again yourself. [NURSE_DN]

Care professional barriers: Almost all CPs felt that FFC in general and discussing FFC with clients would cost them a lot of time, that taking-over tasks would save them time, and that high work and time pressure withheld them from adequately practicing FFC.

Time pressure, for me that is one of the main causes, you have to deal with a busy route, you know that people require care at a specific time, and then you tend to say very quickly 'I will do it myself, instead of them doing it themselves'. [NURSE_SAAH]

Often, FFC was not given priority in contrast to meeting the client's medical and nutritional needs. Many viewed FFC as an additional task to daily care practice instead of an integrated part of their daily care practice, and often it was cited that FFC was only practiced under ideal circumstances, i.e. in case of sufficient time and resources. Sometimes, CPs – and particularly those with a long working history – mentioned that they found it difficult to adopt the rationale of FFC as traditionally they were taught to take-over tasks from clients. Moreover, generally they felt to lack knowledge to transfer FFC information to clients. Researchers' opinions were in line with those of the CPs; they confirmed that CPs brought up time pressure, low priority and a lack of attention for daily care activities as barriers to adequately implement FFC in practice. In addition, researchers believed that many CPs sometimes overestimated themselves thinking they already practiced FFC sufficiently and that they did not always perceive the importance and benefits of FFC.

Organizational facilitators: Facilitating organizational factors addressed by both researchers and CPs comprised of the availability of clear information regarding FFC for clients and family members, and consistency within and support among CPs when implementing FFC. Moreover, having sufficient time and autonomy to practice FFC, and the presence of sufficient staff members and key figures who support FFC, were believed to facilitate its implementation.

Organizational barriers: Too many clients to take care of simultaneously, a lack of or leaving staff members, no support in terms of involvement and visibility from the management, inconsistency in the application of FFC within teams, unawareness of if and how colleagues applied FFC, insufficient time and hindering physical environments were among the organizational barriers mentioned by participants. Organizational barriers put forward by researchers were similar, with the addition that existing organizational policy with regard to the stimulation of physical activity should not only be present but also be disseminated and adhered to in daily practice. In addition, according to researchers, it seemed that individual CPs were only willing to change towards FFC if the whole team changed, and that without colleagues, key persons or an external trigger addressing FFC, it would not be implemented. Last, researchers indicated that it could be a barrier if the program was imposed by the management.

Client barriers: Resistance from clients and close relatives were often cited barriers to successfully implement FFC. For example, CPs interpreted that clients were unaware of the benefits of FFC, forgot to implement FFC in practice, were unwilling to collaborate, and resisted to change. Although some clients were believed to be in favor of performing FFC, the mindset of clients was generally interpreted as negative as they stated they were too old or ill to engage in FFC, or that they resided in the situation that they required assistance in day-to-day tasks. CPs viewed it harder to implement FFC in clients with psychogeriatric complaints, clients with fluctuating capacities, and those who were admitted for a longer period of time. The resistance of close relatives of clients manifested in that they felt their relative should be taken care of instead of completing tasks themselves. No client facilitators emerged from the focus groups.

Discussion

This study aimed to thematically synthesize findings from nine focus-group interviews; eight previously conducted as part of the process evaluations of three Dutch FFC-programs implemented in various nursing care settings, and one newly conducted focus-group with researchers involved in the development, implementation and evaluation of the three Dutch FFC-programs.

Despite their equal aim to optimize daily functioning and independency of older people, there was considerable variation between the Dutch FFC-based programs in how the care philosophy and its components were addressed. A recent review on the effectiveness of FFC-programs from various countries in nursing homes, also demonstrated a wide variety in the structure, content and application of care philosophies and its components [24]. Not only within settings, but also across settings and countries, programs vary widely in their design and application of underlying care philosophy and its components [22,31], which hampers clear comparisons and determining its valuable components. However, it is well known that programs that aim to optimize daily functioning and independence of older people benefit from incorporating a multi-component approach. For instance, education alone - which has been the core component in current Dutch FFC-programs - is viewed as insufficient, and an integrated approach including a review of the policy and environment, supervisory support, and continuous motivation and mentoring is considered pivotal for a successful implementation of FFC [19,32]. To establish this holistic multi-component approach, this study provides lessons learned and implications for all separate components and the development of an advanced generic FFC-program.

Policy and environment

Organizational policy and a facilitating environment were considered important prerequisites to successfully implement FFC. This study shows that not merely the availability of FFC directed policy, but also its clear communication to employees, clients and relatives, and its activation in practice was considered a prerequisite to a successful implementation. The presence of policy and procedures with regard to FFC and its implementation before the start of a FFC-program is noted as useful to assure a successful implementation of FFC [16,19]. Moreover, understanding the policy can help identify barriers, which can be addressed in programs that aim to enhance FFC-behavior [19]. In addition, broad organizational support and involvement from all layers within organizations, in terms of time, resources and visibility, was believed key in order to support care professionals to adequately implement FFC. A thorough

and continuous evaluation of the environment and optimizing the environment accordingly should also be part of the implementation of FFC. In the nursing home and hospital setting, the organization should be responsible for an activity-enhancing environment. Simple and cost-efficient adaptations can be made such as improved lightning and the use of nudges [19]. Particularly in home care, but also in the living environment of those residing in a nursing home or hospital, direct CPs should be aware that the environment is subject to continuous change, and that a thorough assessment of the fit between the person and their environment may be required [33].

Education

Alongside policy and a facilitating physical environment, a comprehensive educational component is suggested in order to change CPs' behavior in light of the shift to social care and person-centeredness. As CPs are deemed to change their professional day-to-day care behavior, an educational emphasis is primarily required on behavior change in themselves. In doing so, interactive and practice-oriented sessions are suggested that provide ownership to the CPs, that aim to enhance CPs' motivation and willingness to practice FFC, and that are tailored to the professional's needs.

Contrary to the generally school-based approach in current educational components, interactive and practice-oriented sessions were preferred, thereby meeting the participants' needs for autonomy and mutual learning [10,34,35]. Moreover, by providing participants ownership and relatedness, the intrinsic motivation to implement FFC could be enhanced, which was seen as an ultimate outcome by researchers [10]. Interactive components have been suggested earlier as part of educational sessions [24], for example role-plays, exercises that stimulate involvement, and discussions to share experiences [36]. Such interactive elements may also provide CPs with a realistic view of their own behavior, which is important, as CPs tend to overestimate their FFC-behavior in practice [35,37]. Another way to increase interaction is to enhance multidisciplinary involvement in future programs in order to increase the contribution of knowledge from different perspectives [38,39]. For instance, the expertise of physical and occupational therapists and other care professionals surrounding the client could contribute to a better understanding of their capabilities - a key principle of FFC - and to a better attunement of personalized FFC-goals [38,40].

All educational components of the Dutch programs started with creating awareness in CPs of their current FFC-behavior and by enhancing FFC knowledge. Afterwards a large part of the educational components of those but also previous programs, focused on how to change and optimize functional activity in clients [24]. To enhance the transition from medical care to social care, a shift might be needed towards a weighed dual process-approach with primarily and more thorough attention to behavior change in CPs. For instance, by besides creating awareness, also focusing on more proximal determinants of behavior change such as motivation, willingness and self-regulatory capacities [41,42]. From a behavior change perspective, creating awareness is an important prerequisite of engagement in a desired behavior [43]. Knowledge as well as behavioral cognizance - the process of gaining a correct insight into one's own behavior - are important awareness determinants [44], particularly because care professionals tend to overestimate the amount of time they spend assisting clients in ADLs [37]. In fact, interviewees agreed that awareness creation proved a key element in the education and that the different programs mainly achieved awareness as a final result. A recent integrative review of nurses' perceptions of their role in FFC behavior concluded that nurses do understand the importance of FFC but often fail to carry out its principles [45]. Being aware of one's own behavior and acknowledging the importance does therefore not seem to guarantee its application in practice. Integrative models of behavior change such as the Integrated Change Model, emphasize that awareness is in fact rather distal to behavior, and mediated by a person's motivation, intention and self-regulatory capacities [46]. Despite the fact that within the FFC-philosophy and educational components limited attention has been paid to motivational constructs such as self-efficacy and outcome expectations [19], only minor changes were observed in practice towards FFC-behavior. This could indicate that the by researchers ultimately desired mindset change, willingness and intrinsic motivation to carry out FFC was indeed not fully achieved.

In addition, this study showed that many CPs - according to themselves but also based on researchers' views - did not prioritize FFC, did not see the importance and added value of FFC, and that they believed that FFC would cost them more time compared to traditional care provision. Although the benefits of the social care approach have been recognized in this and previous studies [11,12], the assumed motivation may be tempered by these negative outcome expectations and barriers in daily practice. It is acknowledged that CPs' willingness to optimize older people's engagement in functional activity may be hindered by such negative outcome expectations [35] and that if nurses do not perceive immediate adverse consequences of not delivering FFC behavior they are less likely to prioritize it [45]. As the current Dutch programs mainly addressed the benefits of FFC for clients, it is pivotal to also dwell on the benefits for CPs of delivering FFC, such as those that have emerged from this study, e.g. improved collaboration with clients and among colleagues. However, of equal importance may be the support in terms of time and staffing resources from the management. As it seems that CPs are unwilling to invest time in short-term to stimulate clients, these known barriers need to be addressed and dealt with in future programs [11].

Last, researchers and CPs mentioned that the content of FFC-programs should be tailored to the current level of FFC, the knowledge of the CPs, the setting FFC was to be carried out in, and the client's capacities. For instance, CPs or clients of a particular team may be more willing to practice FFC and more educated about its advantages than others. This emphasizes the need for programs that are aligned to the particular profile of an individual or team, which will generally be perceived as more personally relevant compared to generic programs [34]. Tailoring content to specific needs of the target population may stimulate greater cognitive processing of information, which is important when assuming a deliberate process in behavior change [35,47].

Coaching

Practice coaching should ensure that FFC is put and consolidated in practice [19]. However, this component appeared to be underexposed in current programs, apart from the hospital program. According to the FFC-philosophy, a nurse champion could be appointed to

facilitate the implementation process in practice [48]. However, there seems to be a debate whether certain nurses should be made responsible to facilitate this process, because researchers suggested that making someone responsible for coaching made other CPs feel less responsible to implement FFC. The preferred way to shape coaching, as suggested by participants in this study, was to discuss client cases in team meetings, periodically put FFC and coaching on the agenda, one-on-one supervision, walking rounds together, giving each other feedback, and having a point of contact. This implies that - although having a point of contact is considered desirable - the delivery of FFC is rather a team effort where a team of nursing CPs work together to support each other and their clients to engage in FFC. In fact, given the difficulty of the required behavior change in clients and CPs as suggested earlier, champions may need support from others themselves [48]. Still, one or more champions could act as persons who keep the attention for FFC in practice, thereby making sure these champions possess the attributes suggested in this and earlier studies such as knowledge, dedication and confidence [48,49]. In home care, creative ways need to be explored on how coaching can be facilitated in practice, for instance by exploring the suitability of peer collaboration or individual reflection.

Strengths and Limitations

This study has several strengths and limitations. First, this synthesis builds on opinions of both participants in the programs and researchers involved in the development, implementation and evaluation of those programs. Second, this synthesis focused on FFC-programs implemented throughout the entire care continuum, i.e. at home, in nursing homes or in acute care systems, thereby allowing comparisons across various care settings. Last, the qualitative design of the study yielded in-depth findings, however, the weight of evidence in qualitative studies is generally rather moderate and quantitative research studies are required to reinforce current results.

Conclusion

This study has shed light on several lessons and implications that are considered important to address in prospective FFC-programs, independent of the care setting in which the program is applied. A holistic multi-component approach is suggested including an interactive and comprehensive educational component that primarily addresses the required behavior change in day-to-day care behavior in care professionals. Furthermore, we suggest to develop FFC-programs that are widely applicable in a variety of nursing care settings, but take into account setting-specific components and allow for tailoring its content to the needs of its participants.

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