Exploring nursing staff's experiences with observing problem behaviour of residents with dementia in a nursing home. A qualitative study.

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Abstract

Title: Exploring nursing staff's experiences with observing problem behaviour of residents with dementia in a nursing home.

Background: : Most people with dementia living in a nursing home exhibit problem behaviour. To diminish problem behaviour, personalised integrated intervention is needed, addressing the multifactorial causes of the behaviour. Observations of nursing staff, when providing care, can support identification of problem behaviour and information about possible causes. However, little is known of nursing staff's experiences with observing problem behaviour.

Aim: To explore nursing staff's experiences with observing problem behaviour of residents with dementia in a nursing home.

Method: A general qualitative study utilizing semi-structured interviews until data saturation, involving 12 participants recruited from one nursing home. Thematic analysis of data was conducted within a constructionist framework to emphasise the nursing home's sociocultural context. A member check was carried out by summarising responses at the end of each interview and presenting the themes in a team-meeting.

Results: Four themes emerged regarding nursing staff experiences which affected their observations: group harmony (observation focused on disruptive behaviour within the group), intuitive approach (unconsciously observing without a method), reactive intervention (not exploring the causes of behaviour), and sharing information (delayed sharing of observed behaviour with other disciplines).

Conclusion: Observing the group harmony comes at the expense of the individual resident with dementia. Since, nursing staff rarely observe problem behaviours such as depression, apathy, and anxiety and do not look methodically for the causes of individual behaviour. This hinders a timely personalised integrated intervention of problem behaviour.

Recommendations: Education of nursing staff to methodically observe and analyse problem behaviour and coaching of the experts in the multidisciplinary to promote their knowledge and skills.

Key words: dementia, problem behaviour, nursing home, nurse, observation, experiences.

Samenvatting

Titel: Exploreren van de ervaringen van verplegend personeel met het observeren van probleem gedrag bij bewoners met dementie in een verpleeghuis

Achtergrond: Het merendeel van mensen met dementie die in een verpleeghuis wonen vertoont probleemgedrag. Een persoonlijke integratieve behandeling, gebaseerd op onderliggende oorzaken van het gedrag, vermindert het probleemgedrag. Verplegend personeel kan een bijdrage leveren aan het ontdekken van probleemgedrag en mogelijke oorzaken, doordat zij observeren tijdens de zorgverlening. Echter, weinig is bekend over ervaringen van verplegend personeel met observeren van probleem gedrag.

Doel: Exploreren van ervaringen van verplegend personeel met het observeren van probleemgedrag bij bewoners met dementie in een verpleeghuis.

Methode: Algemeen kwalitatief onderzoek met semigestructureerde interviews bij 12 participanten totdat datasaturatie was bereikt. Data werd thematische geanalyseerd vanuit een constructivistische raamwerk om de sociaal-culturele omgeving van het verpleeghuis mee te nemen. Een member check was uitgevoerd door een samenvatting na ieder interview en het presenteren van de thema's tijdens een teamoverleg.

Resultaten: Vier thema's kwamen naar voren uit ervaringen van verplegend personeel die de observaties beïnvloedde. Groepsharmonie (observaties richtte zich op verstorend gedrag in de groep), intuïtieve benadering (onbewust observeren zonder methode), reactieve interventie (niet onderzoeken van de oorzaken van het gedrag), delen van informatie (laat delen van geobserveerd gedrag met andere disciplines)

Conclusie: Het observeren van de groepsharmonie gaat ten koste van de individuele bewoner met dementie. Dit komt doordat verplegend personeel zelden probleemgedrag zoals depressie, apathie en angst observeert en doordat zij niet op een methodische wijze de oorzaken van de gedragingen onderzoeken. Dit staat een tijdige persoonlijke interventie van probleemgedrag in de weg.

Aanbevelingen: Scholing van het verplegend personeel in het methodisch observeren en analyseren van probleemgedrag en begeleiding door experts uit het multidisciplinaire team om kennis en vaardigheden te verbeteren.

Sleutel woorden: dementie, probleemgedrag, verpleeghuis, verzorgende, observatie, ervaringen.

Introduction

Dementia is a syndrome in which impaired memory plays a key role (1). People with dementia are increasingly dependent on others for activities of daily living due to progressive cognitive, functional, and behavioural deterioration (2). In the Netherlands, the majority of people with dementia are eventually admitted to a nursing home (3), defined as a domestic-style environment providing 24-hour support and care for residents (4). These environments can vary from a large home with a dementia-specific unit to small living facilities for people with dementia (5). Studies have shown that 75–91% of nursing home residents with dementia exhibit problem behaviour (6,7), which refers to behaviour that leads to suffering and/or causes danger to the person with dementia or people in their surroundings (8). These behaviours are categorised by neuropsychiatric symptoms (NPS) (9). The prevalence of the most common NPS are as follows: depression (43.9%), apathy (43.1%), anxiety (41.6%), and agitation/aggression (31.2%) (7). It has been well established by a variety of studies that only interventions with a methodical multidisciplinary integrated approach diminish problem behaviour (10–14). Examples of such interventions include the integrative reactivation and rehabilitation program (IRR) (10), the stepwise multicomponent intervention (STA OP) (14), and the grip on challenging behaviour care program (GRIP) (12). In these approaches, the multifactorial causes of the problem behaviour are analysed in the biological, psychological, and/or social domains to develop personalised integrated treatment (8).

Person-centred care (PCC) (15) is the international standard approach to dementia care (2,8,16) and places the person at the centre of their own care (17). It implies that people with dementia are first and foremost to be seen as a person with their own history, thoughts, and feelings (8). Therefore, personalised integrated treatment must also be tailored to the needs, preferences and possibilities of the resident (8). Based on the underlying causes of the behaviour and the resident's needs, various disciplines (such as the physician, psychologist, and nursing staff) should work together in a methodical way to determine the treatment (12). To sustain this, the Dutch guideline (2018), 'Problem Behaviour of People with Dementia' describe six phases to determine a personalised integrated treatment: description and clarification of the problem, additional research, definition of the problem, treatment aims, personalised integrated treatment, and evaluation (8).

Early recognition of problem behaviour is important to start a personalised integrated treatment as soon as possible (18). However, most residents with dementia are unable to ask for help themselves, due to their cognitive impairment. Physicians and psychologists do not see residents on a daily basis in a nursing home; thus, they use observation instruments

and medical tests to analyse the causal factors of problem behaviour (8). Nursing staff in nursing homes have the opportunity to observe residents' behaviour on a consistent basis (19). During care activities, the nursing staff makes daily observations based on interactions occurring naturally between the residents and staff (20). These provide information about residents' actual performance (21), allowing staff to share additional information in the multi-disciplinary team about problem behaviour of residents to support early recognition and analysis of multifactorial causes.

The nursing staff is in a unique position to make valuable observations; however, very little focus has been placed on the role of nursing staff in observing problem behaviour. Qualitative research has only explored nursing staffs' perspectives on aggressive behaviour and on problem behaviour of residents with dementia (18,22–29). The growing number of people with dementia (30), the prevalence of problem behaviour (7), and the role of nursing staff in observing problem behaviour (8), highlight the need to explore their experiences of observing problem behaviour to inform policy and management practices.

Aim

The aim of this study is to explore nursing staff's experiences with observing problem behaviour of residents with dementia in a nursing home.

Method

Design

A generic qualitative research design was used in this study. This design was chosen in order to obtain a comprehensive description of nursing staff views, through utilizing their own language to convey their experiences (31). Further, the flexibility of this design was appropriate for the under-researched subject of the study (32). Reporting of the findings was based on the consolidated criteria for reporting qualitative research (COREQ) (33).

Population, domain and sample

The research population consisted of nursing staff caring for people with dementia in a nursing home.

Inclusion criteria for the purposive sample included working as nursing staff in direct contact with people with dementia in a nursing home, working 16 hours or more per week, having at least one year of experience in caring for people with dementia, and speaking Dutch fluently. To be able to observe behaviour, nursing staff had to take care of people with dementia on a regular base. In order to achieve sample variance, staff was considered eligible to participate in the study regardless of the participant's level of education in nursing. Thus, registered nurses (with or without a bachelor degree), certified nurse assistants, nurse

aides were included in the study. Participants were recruited until data saturation, when no new categories occurred from the data which were important to answer the research question (34).

The study was carried out in one nursing home with two units, each containing 20 residents with dementia. The nursing home was chosen as it was representative of the majority of nursing homes, in that a PCC approach is used and a multidisciplinary team is consulted, both of which are standard procedures (8). The characteristics of the units varies between a large nursing homes with dementia specific unit and small living facilities for people with dementia. Each resident had a separate room with their own furniture as well as common areas where they ate together and participated in group activities with other residents. The nursing home was located in an urban area of the Netherlands.

Ethical issues

The study was conducted according to the principles of the Declaration of Helsinki (35), and the Standards of Good Clinical Practice (36). Handling and storage of personal data complied with the Dutch Personal Data Protection Act (37). Participants were not subject to treatment and no code of behaviour was dictated, thus, this constituted a non-WMO study and local regulations of the institute were followed (38). In addition, the management of the nursing home approved the study. Data was processed anonymously and stored for 10 years on a secured research site. The data is owned by Lectoraat Hogeschool Rotterdam.

Procedures

The team manager verbally informed eligible participants about the study. After one week time for consideration, those who wanted to participate sent an e-mail to a secretary and received written information and an informed consent form. The researcher ensured the eligibility of the participant before the interview process. Participation was voluntary, and both the participants and researcher signed the informed consent.

Data collection

Individual interviews were conducted in order to facilitate in-depth discussions on observing the behaviour of people with dementia, which can be a sensitive subject (39). A semi-structured approach was chosen to allow the participants to express themselves freely and the researcher to seek clarification, ensuring that all required information was obtained (40). The interview guide was based on previous literature and the professional knowledge of the researcher (see Table 1). To confirm the suitability of the interview guide, two pilot interviews were carried out prior to the study, which resulted in the reformulation of one question to improve clarity. The content of the pilot interviews was of insufficient quality, and were thus excluded from data analysis.

[insert Table 1]

Interviews were conducted by the primary researcher (EG) in an office in the nursing home to ensure privacy, and field notes were recorded after each interview. The researcher performed a member check to monitor if the participants' responses were correctly understood and to give participants the opportunity to challenge the ideas of the researcher (34). This way a "true" representation of the experience of each participant was ensured (34). The researcher also kept a record of decisions and memos made to ensure reliability and avoid loss of data (34). The data collection was continued until data saturation was achieved (34) a step which was discussed with the study's supervisor (TB). Interviews were conducted, between February and April 2019, and were audio-recorded.

The primary researcher is an experienced nurse currently working as a nursing teacher. However, she has never worked in a nursing home with people with dementia. This lack of familiarity with the research population and EG's resultant curiosity about the research subject increases the study's authenticity (32,34). The researcher was aware of her own pre-existing theoretical knowledge and assumptions about nursing care. In addition, no relationship existed between the researcher, participants, and management of the nursing home. The primary researcher was a novice researcher; thus, she was supported by an experienced supervisor MD PhD (TB) and a second researcher MSc (PA) through discussion of the study's progress.

Data analysis

The researcher analysed the data using thematic analysis within a constructionist framework to emphasise the sociocultural context (32) of a nursing home, since observations can be influenced by sociocultural context. This framework does not focus on individual experiences; rather, it allows one to gain insight into the structural sociocultural conditions (32) that influence observations. The researcher used an inductive analysis approach to explore the experiences of the participants, since this is an under-researched topic (32). The data was analysed using Atlas-ti 8 (GmbH). After conducting an interview, the researcher began analysing the data, such that analysis occurred simultaneously with data collection. The interview guide was adjusted twice after consultations with the supervisor, due to new insights that emerged from the data.

The primary researcher followed six phases of a thematic analysis (32). In the first phase interviews were transcribed verbatim and re-read. Thereafter, initial codes were made of the entire data in the second phase, to get a rich overall description of participants experiences. In the third phase, initial codes were analysed and collected to develop potential themes. Themes were identified at a latent interpretive level, since this is appropriate for a constructionist approach (32). A initial thematic map was generated in the fourth phase, through reviewing all the codes of the potential themes and reading the whole dataset again

to examine if they formed a pattern. The final thematic map was developed through a refinement of the names and definitions of the themes in collaboration with the supervisor and second researcher (phase five). In the last phase a final analysis was done, thereafter the report was formulated and reviewed by the supervisor.

Results

Data saturation was achieved after interviewing 12 nursing staff members, whose details are provided in Table 2. The mean duration of the interviews was 56 minutes (range 52–64). Two men and 10 women participated in the study. The mean duration of working experience in dementia care was 14 years (range 1–30). Two participants declined to take part in the study, after finding the interview too demanding. The researcher performed a member check in two ways. The researcher summarised at the end of each interview the participants' to ensure the answers were correctly understood. Furthermore, the researcher presented the thematic map and explained the definitions of the themes to the participants in a team-meeting. All participants recognised the themes.

[insert Table 2]

From the thematic analysis of data four main themes emerged containing a variety of sub-themes. The main themes were: group harmony, intuitive approach, reactive intervention, sharing information. Group harmony appeared to be the predominant theme, influencing the other main themes. Nursing staff focused on maintaining harmony in the group, thus observing the resident group instead of individual residents. Observing residents form a group perspective influenced the other main themes. Table 3 outlines both the main themes and sub-themes, which are explained below and substantiated by quotations from the interviews.

[insert Table 3]

Group harmony

This theme consists of two sub-themes that describe the way in which nursing staff observed to maintain harmony in the group.

Viewing the residents as a group.

The participants' main objective was to create a safe and secure environment for residents with different backgrounds, needs, and demands who were forced to live together, involuntarily forming a society:

> *Peace and quiet of the group is important because, I think for the resident it is very nice if there is calmness. That they really feel at ease, that they are fine and feel safe.(P 9, certified nurse assistant).*

Participants considered maintaining group harmony to be their main responsibility, in order to achieve ‘a nice day’ for every resident. Therefore problem behaviour of residents was observed from a group perspective. Most participants defined problem behaviour as behaviour that was disruptive to other residents, family, or staff:

> *I think problem behaviour is behaviour that is a burden for other people. (P12, certified nurse assistant).*

Participants considered physical and verbal aggression to be the most commonly observed of these behaviours. Only one participant described passive behaviour as a form of problem behaviour. Most observations focused on the group.

Social interactions between residents.

When a conflict in the group was observed, participants focused on the resident or residents disturbing the harmony. Participants also noted that individual disturbing behaviour was easily adopted by the group. Uncontrollable escalation within the group was perceived as a significant danger that must be prevented. Thus, participants deemed it important to observe residents’ physical, verbal, and non-verbal interactions, so that they could intervene in time:

> *There was a lady who interfered with all the residents around her. Then she says yes, but I have to go home. Then she has forgotten that she lives here. But then she goes to other residents, I want to go home, do you want to go home too? ….That goes on and on, and then it goes on like a wildfire over that department. ...You have to stop that, otherwise everyone wants to go home. (P8, certified nurse assistant).*

Intuitive approach

Intuitive approach describes how observations of residents’ behaviour were obtained in two sub-themes: unconscious and without using a method.

Unconscious observing.

The participants were unaware of the way in which they observed problem behaviour. They explained that observation was not an activity on its own; rather, it occurred during caregiving. As a result, nursing staff was unable to describe the way in which they made observations. Some participants explained their observations as a natural talent or gift:

> *You say I will observe; how do you do that in your busy daily activities?*
> *That actually goes unnoticed. Actually, you scan the whole day to see what happens. You are busy here and you can immediately see what happens in another corner. I think I have that as a gift, a bit. Yes, yes (P1, certified nurse assistant).*

Not using a method. Participants did not use a particular method to observe residents' behaviour; rather, they considered the observation of problem behaviour to be a skill learned from practical experience:

> *And do you use a certain method?*
> *No, it's really just watching how someone responds. I just talked it over last time with my colleague; I find it so special that someone no longer knows who his children are...But actually, I take no time to look for the theory behind it (P9, certified nurse assistant).*

Overlooking the residents' group was believed to be an important requirement of nursing staff; however, all participants unanimously agreed that no focus was placed on theory of behavioural observation during their nursing education. Some participants doubted that knowledge could support the observation of behaviour.

Reactive intervention

Reactive intervention, refers to how nursing staff detected triggers and the way they determined interventions.

Detecting triggers.

Participants observed the triggers of problem behaviour, defining a trigger as a cause of change in individual behaviour, such as noise, crowds, a specific person, or physical discomfort. The participants searched for triggers by repeatedly observing the residents and identifying the relationship between the change in behaviour and the causative factor. The spontaneous determination of a trigger was used to restore harmony through its removal, without exploring the origin of the resident's problem behaviour. Participants considered this instant intervention to be necessary:

> *Can you give another example of a trigger?*
> *Yes. Sometimes you see it after family visits. That sad lady who stays with us, when her husband comes over, then she wants to go home…Then we know, if he doesn't leave soon, we will enjoy it for a few hours. She is restless, angry, cries a lot, throws her bag on the floor…while if you distract her for a moment and he goes away quickly, that's a lot less (P5, certified nurse assistant).*

Trial and error in determining intervention

Participants often mentioned distraction, moving a resident to a quiet place, and providing comfort as suitable interventions to eliminate a trigger. The most effective intervention for an

individual resident was discovered by trial and error after observing the effect of the intervention:

> *It's just trial and error...with the magic table or watching television. Very often it is trying to see if something works…watch how they react to it (P5, certified nurse assistant).*

There was no deliberation or analysis before and after the intervention to determine the appropriate measures for individual residents, based on the cause(s) of the behaviour.

Sharing information

Nursing staff shared information about observed behaviour within and outside the team, which are described in the two subthemes below.

Reflection within the nursing staff team

The participants considered an experienced nursing team to be responsible for and able to solve problem behaviour. Participants were aware that their approach influenced the behaviour of residents and they felt responsible for these consequences. They reflected with each other on whether their approach in fact diminished or triggered problem behaviour. As the behaviour occurred, they discussed it amongst themselves, but the process lacked analysis or evaluation. Participants examined the behaviour from different perspectives and exchanged experiences to find agreement in care:

> *One resident shouts a little more and the other demands a little more and the other is a little more aggressive...because some residents you can't change...And if it gets [to be] a burden for them, I think we should act (P4, registered nurse).*

Barriers to consulting with a multidisciplinary team

Participants mentioned that they only consulted the multidisciplinary team when it was beyond their capabilities to restore harmony within the group, since, in their opinions, it was difficult to share and explain observed behaviour, as understanding can only be achieved through experience. Many participants felt that they were not taken seriously by other disciplines. However, some mentioned that the multidisciplinary team provided useful recommendations, although others doubted that their solutions were useful:

> *I think the psychologist who has no experiences with daily care ... they just see pieces of problem behaviour. Maybe they lack experience to fully understand it or something. They also rarely come up with ideas to help us." (P 6, nurse aide)*

Discussion

The key findings of this study were, first and foremost, that nursing staff observed the problem behaviour of residents from a group perspective, focusing on those who were

disturbing the harmony in order to intervene in a timely manner. Observations were made in an intuitive way, unconsciously and without a method. A reactive approach was used in the immediate removal of the observed triggers without investigation into the underlying cause(s) of the behaviour. The nursing staff team felt responsible for solving the problem behaviour as a group and therefore only consulted the multidisciplinary team when the situation became unmanageable.

The most obvious finding to emerge from the analysis is that the daily observations of nursing staff focused on the residents as a group, in that sustaining the harmony was viewed as critical. Previous literature, exploring views' of problem behaviour, does not suggest that nursing staff observe the resident group instead of individual residents (18,22,23,25,26,28). However, nursing staff has long-term close contact with residents during caregiving (41); subsequently, they also benefit when peace is not disturbed within the resident group, which may explain the importance they placed on group harmony.

Government policy in the Netherlands in recent years has focused on reducing the use of psychotropic drugs and freedom-restricting measures for people with dementia (42,43). These approaches are taken towards those who display agitation or aggressive behaviour. With this change in policy (43), the government also highlighted disruptive problem behaviour. Participants' focus on maintaining group harmony in this study meant that only disruptive problem behaviour was observed. However, apathy, depression, and anxiety are forms of problem behaviour with a higher prevalence than disturbing problem behaviour such as aggression and agitation (7). Thus, nursing staff only observed a small part of the existing problem behaviour. This finding from our research contradicts previous research which found that 'quiet' problem behaviour is also observed by nurses (22). Since the participants in this latest study were all registered nurses, the difference in education level between both studies' participants may explain the variation in findings (44). Nurses are taught to observe and analyse behaviour in a methodical way during their education, as opposed to certified nurse assistants and nurse aides (45).

The interventions that the nursing staff used for aggressive behaviour, such as distraction, personal attention, and bringing the resident to a quieter place, are considered compatible with a PCC approach (25) and are preferable to psychotropic drugs and freedom-restricting measures (46). However, to be effective for the individual resident, an intervention must be based on the cause(s) of the problem behaviour (10–13): the cause must be addressed rather than the behaviour itself (43). The intuitive way in which nursing staff observed the behaviour while providing care and the reactive interventions that followed led to the cause of the behaviour remaining unidentified. These interventions restored harmony to the group but did not resolve the cause of the behaviour for the individual resident. Although the prevention

of escalation between residents is positive and in line with government policy, nursing staff must thus look further into the cause of the behaviour (8).

As well, problem behaviour was recognised in real time by the nursing staff but shared with the multidisciplinary team only after a delay, which prevented a timely approach to its resolution. A methodical multidisciplinary approach targeting the cause of problem behaviour is needed in order to reduce it (10,12–14). The Dutch guideline on problem behaviour prescribe a methodical multidisciplinary approach in order to develop a collaborative problem-oriented and targeted treatment plan (8). However, using a methodical approach to observing and analysing the problem behaviour of people with dementia requires knowledge and skills (42,43,45,47). The nursing staff indicated that they were insufficiently trained in methodically observing and analysing behaviour, a statement supported by the literature (45). Government policies advise a coaching role of experts from the multidisciplinary team, such as psychologists and physicians, to promote knowledge and skills amongst nursing staff (43). Unfortunately, participants did not seem to be supported by other disciplines from the team. Education of methodically observing and analysing behaviour, supports the nursing staff to explore possible causes of behaviour, thereby helping them to report the observed behaviour from the perspective of their profession to the multidisciplinary team in an efficient manner. This is important for the resident, to provide a timely personalised integrated intervention to diminish problem behaviour.

This study has some limitations. It was conducted in a single nursing home, and although this nursing home was chosen because it was representative of the majority, this limited sample may affect the transferability of the results. Further research may be warranted into the experiences of nursing staff observing problem behaviour in other organisations and different care settings, such as small living facilities, psychogeriatric rehabilitation departments, and large psychogeriatric wards. Further, data was collected only through individual interviews, making it difficult to determine whether participants' claims reflect their actions in observing residents. Still, the strength of this study is that it provided new insight into the perceived importance of observing disturbances to group harmony.

Conclusion

Since nurses mainly focus their observations on the disturbance of group harmony, less focus is placed on observing the individual resident with dementia. Problem behaviours such as apathy, depression, and anxiety were hardly observed in comparison with more obvious problem behaviours, such as agitation and aggression. Nurses do not observe methodologically; thus, the causes of the problem behaviour are not explored. Observing only the group harmony comes at the expense of the individual resident and hinders a timely personalised integrated intervention.

Recommendations

A focus on methodically observing and analysing problematic behaviour in people with dementia should be included in the education and training of nursing staff. This will lead to nursing staff having a clearer input into the multidisciplinary consultation, where agreements are made about personalised integrated care. Additionally, experts in the multidisciplinary team should coach the nursing staff and promote growth in their knowledge and skills.

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Table 1 Interview guide

Introduction interview- general questions to enable participant to relax
How long have you been working in the area of dementia care? What nursing qualifications do you have? Do you have specific dementia qualifications? If Yes…what are they?
Main interview- focus on the nurse's experiences of observing people with dementia and probing of responses.
What behaviours do you considered as problem behaviour? Can you describe in your own words your definition of problem behaviour? Can you tell me how you observe problem behaviours of people with dementia? What does observing problem behaviours of people with dementia mean for you? What challenges in observing behaviours of people with dementia do you experiences? What is supporting you in observing behaviours of people with dementia? How do you consider your ability to observe problem behaviour of people with dementia?
End interview
Do you feel we covered all relevant areas? Is there anything you would like to add?

Table 2 Participant details

	Gender	Age	Primary qualification	Years qualified	Years working dementia care	Dementia specific training
P1	Female	53	certified nurse assistant	33	30	Specialisation agogic psygo-geriatrics
P2	Female	61	certified nurse assistant	23	20	
P3	Female	39	certified nurse assistant	3	2	
P4	Male	38	registered nurse no bach-elor degree	14	13	
P5	Female	50	certified nurse assistant	29	29	Specialisation agogic psygo-geriatrics
P6	male	47	nurse aide	15	15	
P7	Female	44	certified nurse assistant	25	25	
P8	Male	28	certified nurse assistant	3	3	
P9	Female	25	certified nurse assistant	2	1	
P10	Female	25	certified nurse assistant	4	4	Specialisation agogic psygo-geriatrics
P11	Female	54	nurse aide	12	12	
P12	Female	33	certified nurse assistant	14	14	

Table 3 Main themes and sub-themes of the thematic analysis

Main theme	***Sub-themes***
Group harmony	• Viewing the residents as a group
	• Social interactions between residents
Intuitive approach	• Unconscious observing
	• Not using a method
Reactive intervention	• Detecting triggers
	• Trial and error in determining intervention
Sharing information	• Reflection within the nursing staff team
	• Barriers to consulting with a multidisciplinary team