

# MASTER THESIS

## ***An exploration of the face validity and feasibility of the translated ZELF training guide to home care***

*A qualitative study*

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## **ABSTRACT**

**Title:** An exploration of the face validity and feasibility of the translated generic Function Focused Care intervention training guide to home care.

**Background:** Nurses tend to take over tasks and need to change their behaviour to support older people in physical activity. In the Netherlands, a generic Function Focused Care-intervention for long-term care was initially developed for a nursing home to encourage nursing staff to engage older people to preserve and optimize physical activity. One part of this intervention consists of multiple trainings led by a training guide.

**Aim:** To explore the face validity and feasibility of the translated training guide to home care.

**Method:** A qualitative generic descriptive study was conducted. A working group translated the training guide to home care. Two expert panels participated in focus groups as well as semi-structured interviews to explore the face validity and feasibility of the draft training guide. Data were analysed using deductive content analysis.

**Results:** The draft version of the translated training guide to home care included three meetings. Analysis yielded five themes applicable to face validity and feasibility. Themes were: General expectation of new training, impression of the training guide, training guide contents, missing items and conditions for implementation.

**Conclusion:** The training guide has the right order and looks relevant for clinical practice. It makes nurses more aware of the current situation. Findings show the composition and content of the training guide needs to be reviewed and further developed to eventually achieve a behavioural change in clinical practice.

**Recommendations:** To ensure the feasibility and generalization of the training guide, it should be pilot tested into a wider population of home care nurses from different home care organizations.

**Keywords:** Function Focused Care, home care, face validity, feasibility

## **SAMENVATTING**

**Titel:** Een verkenning van de indrukvaliditeit en haalbaarheid van de vertaalde generieke functiegerichte zorg interventie trainingsgids voor de thuiszorg.

**Achtergrond:** Verpleegkundigen zijn geneigd om taken over te nemen en moeten hun gedrag veranderen om ouderen te ondersteunen in fysieke activiteit. Een generieke functiegerichte zorg interventie voor de langdurige zorg is in Nederland in eerste instantie ontwikkeld voor het verpleeghuis, om zorgteams aan te moedigen ouderen te betrekken zodat hun fysieke activiteit behouden en geoptimaliseerd kan worden. Een onderdeel van deze interventie zijn scholingsbijeenkomsten met behulp van een trainingsgids.

**Doel:** Een verkenning van de gezichtvaliditeit en haalbaarheid op de vertaalde trainingsgids voor de thuiszorg.

**Methode:** Er is een generiek kwalitatief beschrijvend onderzoek uitgevoerd. Een werkgroep is samengesteld om de trainingsgids te vertalen naar de thuiszorg. Twee expert panels namen deel aan focus groepen en semigestructureerde interviews om de indrukvaliditeit en haalbaarheid van het ontwerp van de trainingsgids te onderzoeken. Data is geanalyseerd door middel van een deductieve inhoudsanalyse.

**Resultaten:** De concept versie van de vertaalde trainingsgids voor de thuiszorg bestaat uit drie bijeenkomsten. Analyse leverde vijf thema's op die van toepassing zijn op indrukvaliditeit en haalbaarheid. Thema's waren: Algemene verwachting van een nieuwe training, impressie van de trainingsgids, inhoud van trainingsgids, ontbrekende items en voorwaarden voor implementatie.

**Conclusie:** De trainingsgids heeft de juiste volgorde en ziet er relevant uit voor de klinische praktijk. Het maakt verpleegkundigen meer bewust over de huidige situatie. Resultaten laten zien dat de opbouw en inhoud van de trainingsgids moeten worden herzien en verder ontwikkelt om uiteindelijk een gedragsverandering in de praktijk te kunnen bereiken.

**Aanbevelingen:** De trainingsgids moet bij een bredere populatie van thuiszorgverpleegkundigen van verschillende thuiszorgorganisaties worden getest om de generaliseerbaarheid en haalbaarheid te kunnen waarborgen.

**Kernwoorden:** Functiegerichte zorginterventie, thuiszorg, gezichtvaliditeit, haalbaarheid

## INTRODUCTION

Over four million older people, defined as 65 years or older, are expected to live in the Netherlands in 2030<sup>1</sup>. Majority of these older people remain living at home as long as possible<sup>2</sup>. Consequently, this means that older people living at home should manage their own lives and determine how they receive support when necessary to enable to stay at home, in other words: self-reliance<sup>3</sup>.

Self-reliance is described as the ability of people to help themselves in all areas of life with as little professional support and care as possible<sup>4</sup>. Physical activity (PA) is crucial in sustaining self-reliance in older people living at home<sup>5</sup> and reduces risks of disabilities, fractures, cognitive decline and dementia<sup>6</sup>. Older people spend most of their time physically inactive and having less opportunity to perform tasks independently leading towards rapid functional decline<sup>7,8</sup>. Nurses have a major task in supporting PA. However, nursing staff tend to take over tasks rather than supporting PA among older people<sup>9</sup>. It is therefore needed for nursing staff to change their behaviour from 'doing things for clients' to 'engaging clients' in Activities of Daily Living (ADL). An evidence-based approach that could help nursing staff is entitled Function Focused Care (FFC)<sup>10-12</sup>.

FFC is defined as "a philosophy of care that focuses on evaluating the adult's underlying capability with regard to daily and physical activity and helping him or her optimize and maintain functional abilities and increase time spent in physical activity" (p.4)<sup>13</sup>. Previous studies with FFC-related interventions reported beneficial long-term outcomes such as cost savings<sup>14,15</sup> and improved PA in older people with various levels of capability in different settings<sup>10,11,16-18</sup>. For the implementation of FFC in clinical practice, Resnick<sup>13</sup> suggests four interrelated components: 1.) Identifying FFC barriers and facilitators; 2.) Educating clients, informal caregivers and nurses about FFC; 3.) Establishing FFC-goals together with clients, and 4.) Continuous motivation and mentoring.

In the Netherlands FFC interventions regarding PA have been tested in older people population in hospital (Function Focused Care in Hospital)<sup>19</sup>, nursing home (DAily NURSE)<sup>20</sup> and home care (Stay Active at Home)<sup>21</sup>. These interventions are based on the description from Resnick<sup>13</sup> but are slightly different in the context of how the intervention will be delivered. Similarities within these interventions are the focus of creating awareness about the behaviour of nursing staff towards the encouragement of older people ADL through a training program.

Results of the process evaluation (internal communication<sup>22,23</sup>) of the different setting related FFC-interventions has led to the development of the draft version 'Zelfredzaamheid, Eigen regie, Levenskwaliteit & Functionaliteit' (ZELF) intervention by using the Medical

Research Council (MRC)- framework. The MRC-framework is often used as guidance for developing and evaluating complex interventions<sup>24</sup>. In contrast to the setting related FFC-interventions, ZELF is aimed as a generic FFC-intervention and should be applicable for nursing staff working with older adults in long-term care facilities. ZELF focuses on tailoring on the level of nursing staff as well as older people to be more in line for achieving a behavioural change. The intervention in its current form was based on the process evaluation of previous FFC interventions and consists of 1) one kick-off meeting, four team meetings and two booster sessions for nursing staff (guided by a training guide); 2) two family meetings to explain the rationale of physical activity; 3) involvement from management level.

The aim of the current study was 1) to translate the training guide that specifies the draft ZELF intervention for nursing staff working in a home care setting and 2) to explore the face validity and feasibility of the draft content training guide to home care by an expert panel.

## **METHODS**

### **Part 1**

#### ***Population & Domain***

The first part of this study, focused on translating the training guide from nursing home into a home care version, occurred from January until March 2020. A working group has been composed and consist of participants, with backgrounds in nursing and health science, from two Dutch Universities.

#### ***Data collection***

The scrum methodology was applied during the translation process to collect the data<sup>25</sup>.

#### ***Procedures***

The training guide for nursing home served as the starting point. Participants thought individually about which adaptations were needed and which key items from the training guide could be adopted into the training guide to home care. Results were synthesized in advance by one participant and presented during working group meetings. These results provided the basis for further discussions until consensus was reached.

#### ***Data analyses***

Discussion meetings were used to add, reduce and remove items from the nursing home training guide. Once adaptations were made after each meeting, all participants received a renewed version of the training guide to home care by email.

## **Part 2**

The translated training guide was the basis for the second part of this study.

### ***Design***

A qualitative generic descriptive design was used to assess the feasibility and face validity of the training guide to home care. Face validity determined to the degree to which the training guide is valid regarding the aim and target group of the training<sup>26</sup> and is also an indication whether the training guide is appropriate for further development<sup>27</sup>. Feasibility studies enable researchers to assess whether or not the ideas and findings can be shaped further testing into a wider population<sup>24,28</sup>. Assessment of the face validity of a newly developed intervention for clinical practice can be achieved through a qualitative approach with the population who need to work with the intervention<sup>29</sup>. A generic design seeks to describe the needs, resources and potential challenges that could arise in the implementation of in the intervention, designed to change existing practice, from participants' perspective<sup>30,31</sup>.

### ***Population & Domain***

For assessing the face validity healthcare researchers from two Dutch Universities and nurses working in home care in the Utrecht province were recruited.

Snowball sampling was used to recruit researchers. Participants of the working group were asked to recruit researchers from their network for this study<sup>32</sup>. Not being involved in the developmental process of the training guide to home care was the only criterion for researchers to participate in the study.

Home care nursing staff were recruited by convenience and snowball sampling with maximum variation to include a variety of skill levels to represent different levels of nursing in home care<sup>32,33</sup>. Direct home care colleagues of the first researcher (JD) were approached to participate in the study<sup>33</sup>. Nurses were eligible if they were working with older people ( $\geq 65$  years) living at home, have been working in home care for more than one year, did not have left home care not longer than one year prior the study and were working in a team where the manager is intimately involved in clinical practice.

### ***Data collection***

Online focus groups- and individual interviews over telephone were held for this study and took place in April 2020. Interviews and collective discussion during focus groups led to in-depth information were experiences, opinions and potential solutions to problems were generated in order to optimize the training guide to home care<sup>34</sup>. A semi-structured topic guide (appendix A) was developed to explore particular aspects of the training guide but offered the participants the

possibility to share their opinions at the same time<sup>33</sup>. The topic list was based on the output from the different setting related FFC-interventions<sup>23</sup> because there are no standards of how face validity should be assessed due to the subjective nature<sup>27</sup>.

All (focus group) interviews were audio-recorded and conducted by one researcher (JD). Except for five nurses working in home care, the researcher had no further connection to the participants. Approaches in data collection from now are referred to as interviews, regardless of whether this was a focus group or individual interview.

### ***Data analysis***

Interviews were anonymized and transcribed verbatim by one researcher (JD). To become familiar with the data, interviews were read and reread. Data were organized using Nvivo software<sup>35</sup> following the principles of deductive content analysis according to Elo and Kyngäs<sup>36</sup>. This approach consisted of the stages 1) preparation 2) organizing and 3) reporting. A deductive approach is based on previously determined derived categories, and initial coding starts with relevant research findings<sup>37</sup>. In preparation of the analysis predetermined categories been established. These categories were based on the topic list that was also used during the interviews. In the organizing phase, transcripts were initial coded in a deductive way. Initial codes have been arranged in sub-categories which been grouped underneath the predetermined topics to report a general description of the training guide<sup>36,38</sup>. All coding and analyzing were done by one researcher (JD) whereby a working group participant was consulted if necessary.

Member check was carried out to cover the study credibility and confirmability<sup>33</sup>. Participants received a summary of the results by email and confirmed the results. Other activities to enhance study trustworthiness included the development of an audit trail of working group meetings, line-by-line transcripts and data sets<sup>32</sup>. The consolidated criteria for reporting qualitative research (COREQ)<sup>39</sup> checklist have been used to report study results.

### ***Procedures***

Participants who indicated that they were willing to engage in the study received an invitation email from the researcher with a brief description about the research, declaration of consent, guide to using the online resource for the interview and contact details for any further questions. Consensus regarding date and time for interviewing was reached with the participants. Before the interview took place, participants gave verbal consent for participation in research once the audio-recorder turned on. Baseline characteristics were collected straight after the interviews through a case report form.

A reminder has been sent once to researchers after two weeks because of non-response on the first approach.

### ***Ethical issues***

This study has been conducted according to the principles of the 64<sup>th</sup> Declaration of Helsinki<sup>40</sup> and the law of General Data Protection<sup>41</sup>. Due to the nature of the study, the Medical Research Involving Human Subjects Act<sup>42</sup> was not applied. Ethical approval was granted from the Medical Ethics Committee of Maastricht University Medical Centre.

## **RESULTS**

### **Part 1**

Seven participants were involved to translate the training guide from nursing home into a home care version. Participants included nursing scientists (N=2), health scientists (N=2), one with a background in occupational therapy, and nursing science students (N=3) (table 1). Three participants were previously involved in the individual FFC-setting related interventions, whereof two participants in hospital as well as home care and one participant in nursing home.

INSERT TABLE 1

Four working group meetings were needed to establish the content training guide to home care (figure 1) by mutual agreement.

INSERT FIGURE 1

### **Part 2**

Home care nursing staff are all referred to as 'nurses', regardless of whether they were registered nurses or nursing assistants.

Twelve nurses were recruited for the study. Five nurses rejected to participate because of personal circumstances (N=1), feeling not comfortable to take part in a focus group (N=1), has left home care longer than one year ago (N=1) or gave non-response on the invitation (N=2). The focus group interview took place over Zoom. Two nurses have been individually interviewed over telephone because of not being able to use this resource correctly. Baseline characteristics are shown in table 2.

INSERT TABLE 2

Four healthcare researchers (Table 3) have been approached and agreed to participate in a focus group over Zoom. Researchers were health scientists with an educational background in nursing science (N=1), human movement science (N=1), nutrition and health (N=1) and



epidemiology (N=1). One researcher was not involved in the developmental process of any of the individual FFC-setting related intervention but did involve the trial and evaluation process.

The average length of (focus group) interviews was 68 minutes (range: 44 – 92 minutes).

INSERT TABLE 3

### ***Findings from the interviews***

Five main themes and eleven subthemes arose from the deductive content analysis (Table 4). Main themes regarding face validity were: General expectation of a new training and impression of the training guide. Three themes applied to feasibility and consist of Training guide contents, missing items and conditions for implementation.

#### *General expectation of a new training*

A varied training guide, where both theory as well as exchanging clinical experiences can be discussed, is preferred by participants. Opportunity for exchanging clinical experiences during meetings was emphasized as an essential part of any training. Interaction could lead to more in-depth and other perspectives and ensures the link with clinical practice.

*“What do nurses believe? You should try to refute that. One option to do so is to let nurses exchange their experiences”* (participant 11, researcher involved in previous FFC-intervention).

#### *Impression of the training guide*

##### **Order**

According to participants the content training guide has the right order.

##### **Relevance**

Participants mentioned the content training guide looks relevant for clinical practice and is in line with their expectations of a new training. Participants from clinical practice confirmed they see colleagues tend to take over tasks from clients in the current situation. Mentioned causes were not knowing the client very well, hospitalized clients, better communication needed to colleagues about the clients' capability, lack of knowledge and time limitations during care moments or to discuss this during team meetings. Participants think this training could help them to be more aware of it.

*“Because, you become more aware like, yes... What can clients do themselves? What do we actually do with the client what they might be able to do themselves?”* (Participant 7, Nurse)

### **Suggestions for improvement**

To make attendees of the training more aware of the current situation, participants suggested additional items within the training guide that should get attention.

*“To what extend do they [nurses] find it [physical activity among clients] important? I do not see this in the propositions. It also may be that they do not care. [...] Is it part of your profession, part of what you are doing?”* (participant 5, nurse).

The perspective of clients is not covered in the current training guide. Underlying causes, cognitive impairments, families' perspective or unwillingness to perform physical activities while client knows how is aware of it, is missing.

*“What are their norms and values? Habits? [...] and, someone's character, is it someone who is accommodating? Or reluctant? Or want to keep control? Those things, you have to take into account. You can do something with that.”* (participant 2, nursing assistant).

Participants noted a theoretical framework, focused on behavioural change, might be an added value to improve the training guide. By comparing the content items of the training guide with behavioural determinants from a theoretical framework, it can be assessed whether all determinants are addressed in the training guide.

*“We saw it [behaviour change] at the time of our results. In the end it is still remains a sort of blackbox. What, or a combination of which factors, in our program has actually caused a behavioural change? I think, if you use a framework, you can define these to yourself in advance”* (participant 9, researcher involved in previous FFC-intervention).

### **Training guide contents**

#### **Comprehensibility**

Participants mentioned to reformulate, clarify and specify definitions within the items to make the meetings more understandable. Participants had a difference in interpretation whether the experience expert, familiar with an FFC-intervention, need to be a client or nurse. Definitions as 'behaviour' or 'insufficient' might give direction to a variety of answers what might cause digress from the current subject.

*“Everyone [within a team] have an opinion about it. If you have a broad definition, then it just keeps going. If you only talk about physical activity, all members will know what physical activity is. [...] I think self-reliance might be too vague for some people, they do not know what this means”* (participant 5, nurse).

#### **Less pleasant items**

The training session with an actor caused resistance to nurses. Awareness of clinical practice would be missing from actors, causing playing a case study does not reflect the real situation. To make the session easily accessible to nurses, the possibility of role-playing a client by one of the nurses while a nursing colleague or actor apply the FFC-approach was mentioned.

*“Colleagues may be able to empathize better with the role because they see this situation passing by every day”* (participant 6, nurse).

#### **Pleasant items**

Showing a video is appointed as added value in comparison with only an oral presentation or reading theory. A video is clear and nurses immediately know where the subject is going about. Homework assignments force nurses to think critically and practically about learned skills in the current situation.

#### **Potential barriers**

Docile colleagues and limitations in facilities (a small training room for example) were seen as potential barriers by participants. Using digital resources or making mixed subgroups (by a member of the team) in advance may be helpful to gauge knowledge and opinions from all (individual) attendees. Participants advised to review the time-schedule for plenary items mainly. The current time indication might be too short whereby an in-depth discussion maybe can be missed.

#### **Missing items**

##### **Action plan**

Participants suggest adding an action plan to ensure commitment of nurses and clients.

*“In this training guide, I miss an implementation of the meetings. That nurses will make a kind of plan together of ‘what am I going to do differently in clinical practice tomorrow?’ [...] At least then you have the more embedded that nurses think more in-depth about it”* (participant 10, researcher involved in previous FFC-intervention).

### **Preparation (before training starts)**

Participants prefer to receive information before the training starts about FFC, purpose and what the training is about.

### Conditions for implementation

#### **Stakeholders**

Participants prefer the provided meetings will be given by a trainer who is preferably from their organization and is familiar with (the target population of clients in) home care. Long-term assurance in clinical practice is seen as a task of the first responsible nurse of the clients, in combination with a member of the team who can remain coaching colleagues. Collaboration with a manager is essential to implement and embed an intervention successful in clinical practice.

*“We included managers in the training. Firstly “They [managers] have to support the training and they have the possibilities that this training can be given. On the other side, it is also a great opportunity to create support. You get another situation where managers can be easier addressed. They become part of the process. [...] because it must be brought into the limelight of ‘this is how we should act’, that is why that manager is so important. You have to integrate that. It is a separate part of your intervention, but that need to be reflected in your training” (participant 11, researcher involved in previous FFC-intervention).*

#### **Amount of training**

Participants have divided opinions about the number of trainings. Half of the nurses indicated three meetings as enough, while the other half believe extra training would be necessary in combination with reference work and annually recurrences. Nurses prefer a one and half to two-hour training with an interruption of two weeks.

## **DISCUSSION**

This study has resulted in a draft training guide to home care of the ZELF intervention that aimed to achieve a behavioural change on the tailored level of nurses as well as older people. The training guide was translated from the nursing home version and consisted of three meetings. Expert panels, who assessed the face validity and feasibility, regarded the training guide as applicable to home care, relevant and accorded to home care nursing staff preferences. Findings show the composition and content of the training guide need to be reviewed and further developed to eventually achieve a behavioural change in clinical practice.

Findings from this study aligned with the developmental process of the MRC-Framework. Determining the needs and perceptions from existing practice need to be carried out in an early

stage of developing a new complex intervention<sup>24,43,44</sup>. Any potential barriers and facilitators, identified from multiple perspectives, can be taken into account during the further process of development to enhance the workability of the intervention in clinical practice<sup>44,45</sup>. The training guide was assessed as appropriate to home care by nurses, which implies the acceptability in terms of feasibility<sup>28</sup>. Acceptability is a key consideration in designing and implementing healthcare intervention to ensure the effectiveness of an intervention<sup>46</sup>. However, results of this study also indicated further development and refinement of this training guide is needed. Given the results, further development is feasible and appropriate to the aim of face validity<sup>27</sup>. According to the MRC-framework, the training guide should be pilot tested for exploring other parts of feasibility to ensure whether is appropriate for further testing into a wider population<sup>24,28</sup>.

Themes from the interviews were divided into face validity and feasibility. The distinction was based on the meaning of face validity (content parts)<sup>26,27</sup> and feasibility (process parts)<sup>24,28</sup>. Despite this division, the substantive themes are interrelated which made it difficult to decide whether the results should have been presented separately.

A strength of the study is the triangulation in data. The composition of the working group consisted of participants with many backgrounds in different healthcare-related fields. Co-creation has led to the initial draft of the training guide to home care. Both healthcare researchers as nurses were interviewed about this draft version resulting in an assessment of the training guide from many perspectives. Exploring the perceptions from multiple experts established the face validity and increase the external validity of the effectiveness of the intervention<sup>43,47</sup>. Another strength is the representation of all educational levels in home care nursing. The training guide to home care has been assessed by both higher- as lower educated nurses which makes the training guide applicable and understandable for all levels of nursing<sup>27</sup>.

This study has many limitations. The training guide to home care is reduced to three meetings, in compare with the nursing home version which consisted of five meetings. In close consultation with stakeholders from home care was decided to reduce the number of meetings to three to be more feasible for this setting. Aims and items of the training guide for nursing home have been combined in the training guide to home care. As a result, some items in the training guide to home care received less attention compared to the nursing home training guide. For example, coaching within a team. Results show there is indeed a need for coaching in clinical practice. Additional, results show three meetings would not be feasible to achieve a behavioural change. Too many restrictions on an FFC-related intervention could result in a lack of support base and limited interdisciplinary cooperation in clinical practice<sup>48</sup>.

Due to COVID-19 outbreak, focus group interviews took place on-line. The focus group

interview with nurses was mainly represented by nurses, under the age of fifties, who had sufficient computer skills for taking part in an online focus group. Two nurses have been individually interviewed over telephone because of not being able to use an on-line resource correctly. These nurses had considerable years in work experience. Interaction with less experienced nurses in the focus group could have led to more in-depth discussion during the focus groups session. Half of the participated nurses were from one home care organization, which affect the generalizability of the study. Underrepresentation of other home care organizations could lead to sampling bias because of a unilateral assessment on the training guide to home care<sup>32,33</sup>.

Another impact on the study quality and validity is the number of participants in the study<sup>49,50</sup>. Nine participants took part in two focus groups interviews, while data saturation is generally expected after five focus groups with four to five participants<sup>51,52</sup>. It is recommended to carry out several focus groups with nurses from different home care organization for generalizing the ZELF training guide to home care.

The training regarding the ZELF intervention for a nursing home included domestic workers and paramedics closely involved with the client. The training guide as it has been translated and assessed for this study was initially translated to be applicable for nurses working in home care. It is essential to consider how the training can be adapted to make it applicable to domestic workers in home care as well as home care nursing staff to achieve a behavioural change in both groups.

## **CONCLUSION**

The aim this study was to translate the training guide of the ZELF intervention from a nursing home setting into a version that was applicable to home care, followed by an exploration on the face validity and feasibility of this draft. According to participants the training guide has the right order and applies to a home care situation. The training guide will help nurses to be more aware of the current situation in clinical practice and it is line with their preferences for varied training. In line with face validity, the draft training guide to home care is appropriate for further development. Content items within the training guide need to be reviewed to make the trainings more understandable, workable and feasible. Also, the training guide should be compared with a theoretical framework for behavioural change, to assess whether all determinants to change behaviour have been taken into account in the training.

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## APPENDIX A TOPIC LIST (FOCUS GROUP) INTERVIEWS

|                                  |  |
|----------------------------------|--|
| Introduction                     | <ul style="list-style-type: none"> <li>• Introductory round</li> <li>• Aim of the focus group</li> <li>• Method / etiquette online discussion</li> </ul>   |
| Before discussing training guide | <ul style="list-style-type: none"> <li>• General experiences regarding training (nurses only)</li> <li>• Experiences regarding the setting related FFC-interventions (healthcare researchers only)</li> <li>• General expectations (nurses only)</li> <li>• Items were training should consist of</li> </ul> |
| During discussing training guide | <ul style="list-style-type: none"> <li>• Items what does (not) make sense / (less) pleasant</li> </ul>   |
| After discussing training guide  | <ul style="list-style-type: none"> <li>• Length, time, frequency training sessions</li> <li>• Requirements trainer</li> <li>• Assurance in clinical practice</li> </ul>  |

## APPENDIX B TABLES AND FIGURES

Table 1: *Baseline characteristics of the participants who translate the ZELF training guide for nursing home into a homecare version.*

|  |                      | N (=7) |
|--|----------------------|--------|
| <b>Age (Average)</b>                                 | 35.4 (range 26 – 46) |        |
| <b>Background</b>                                    | Nurse                | 5      |
|  | Health Sciences      | 2      |
| <b>Educational level</b>                             | Bachelor             | 3      |
|  | PhD                  | 4      |
| <b>Previously been involved in FFC-intervention*</b> | Yes                  | 3      |
|  | No                   | 4      |

\*Function Focused Care

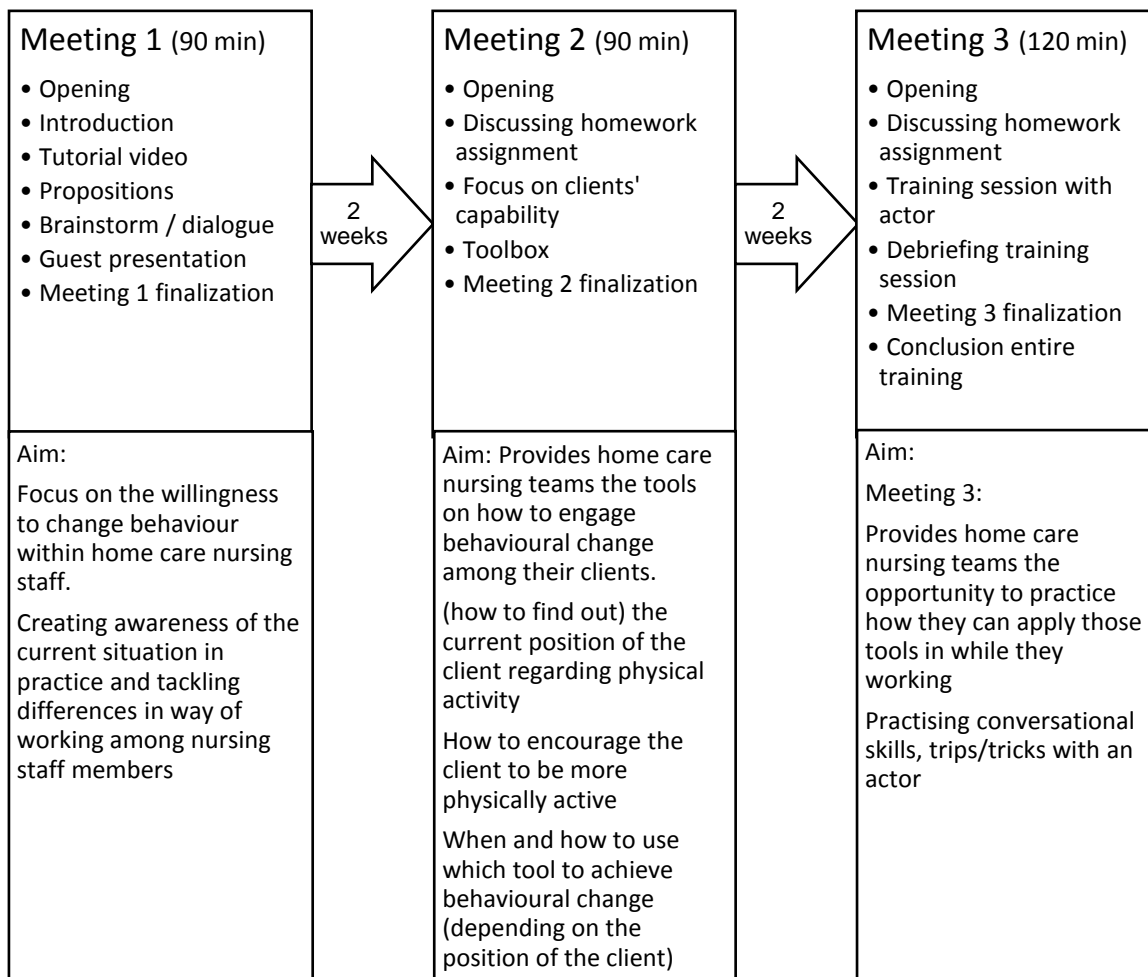


Figure 1: The draft of the ZELF intervention training guide to home care.

Table 2: *Baseline characteristics participants working in homecare*

|   |  | <b>N (=7)</b> | <b>Mean<br/>(in years)</b> | <b>(range in<br/>years)</b> |
|---|--|---------------|----------------------------|-----------------------------|
| <b>Method of data collection</b>                        | Focus group                            | 5             |                            |                             |
|   | Interview                              | 2             |                            |                             |
| <b>Age</b>  | 20 – 30                                | 2             | 37,9                       | (23 – 54)                   |
|   | 31 – 40                                | 2             |                            |                             |
|   | 41 – 50                                | 1             |                            |                             |
|   | > 50                                   | 2             |                            |                             |
| <b>Profession/education level</b>                       | Baccalaureate-trained registered nurse | 3             |                            |                             |
|   | Vocationally-trained registered nurse  | 1             |                            |                             |
|   | Certified nurse assistant (VIG)        | 1             |                            |                             |
|   | Nursing assistant (VAG)                | 2             |                            |                             |
| <b>Contractual hours of work per week</b>               | < 20                                   | 1             | 24,3                       | (9 – 32)                    |
|   | 20 – 30                                | 4             |                            |                             |
|   | > 30                                   | 2             |                            |                             |
| <b>Professional experience in healthcare (in years)</b> | < 10                                   | 1             | 18,1                       | (5 – 35)                    |
|   | 10 – 15                                | 3             |                            |                             |
|   | 16 – 20                                | 1             |                            |                             |
|   | > 20                                   | 2             |                            |                             |
| <b>Professional experience in home care (in years)</b>  | < 5                                    | 1             | 10,9                       | (2 – 17)                    |
|   | 5 – 10                                 | 2             |                            |                             |
|   | 11 – 15                                | 2             |                            |                             |
|   | > 15                                   | 2             |                            |                             |
| <b>Number of colleagues in team</b>                     | < 15                                   | 1             | 19,3                       | (13 – 23)                   |
|   | 15 – 20                                | 2             |                            |                             |
|   | > 20                                   | 4             |                            |                             |

Table 3: *Baseline characteristics of participated healthcare researchers*

|   |                       |
|---|-----------------------|
| Average age   | 40.7 (range: 27 – 53) |
| Master  | 2                     |
| PhD   | 2                     |
| Previously been involved in FFC-intervention*   | 3                     |
| <ul style="list-style-type: none"> <li>• Hospital (FFCIH**)</li> <li>• Home care (Stay Active at Home)</li> <li>• Nursing Home (Daily Nurse)</li> </ul> | 1<br>1<br>2           |

\*Function Focused Care \*\*Function Focused Care in Hospital

Table 4: *Main themes and subthemes arose after analyzing data*

|               | <b>Main themes</b>                    | <b>Subthemes</b>   |
|---------------|---------------------------------------|--|
| Face validity | General expectation of a new training |  |
|               | Impression training guide             | <ul style="list-style-type: none"> <li>• Order</li> <li>• Relevance</li> <li>• Suggestions for improvement</li> </ul>  |
| Feasibility   | Training guide contents               | <ul style="list-style-type: none"> <li>• Comprehensibility</li> <li>• Less pleasant items</li> <li>• Pleasant items</li> <li>• Potential barriers</li> </ul> |
|               | Missing components                    | <ul style="list-style-type: none"> <li>• Action plan</li> <li>• Preparation (before training starts)</li> </ul>  |
|               | Conditions for implementation         | <ul style="list-style-type: none"> <li>• Stakeholders</li> <li>• Amount of training</li> </ul>   |
|               |                                       |  |