EXPERIENCED BARRIERS AND FACILITATORS OF RESEARCHERS AND NURSING STAFF REGARDING FUNCTION FOCUSED CARE - A QUALITATIVE APPROACH
MASTER THESIS

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Status thesis:	Final version
Date:	18-06-2020
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Journal for publication:	Journal of Clinical Nursing
Number of words:	3799
Criteria used:	Consolidated Criteria for Reporting Qualitative Research
Number of words abstract:	299
Number of words samenvatting:	300

Acknowledgements

The author would like to thank dr. S. Vluggen, dr. SF Metzelthin and prof. dr. SMG Zwakhalen for making the data of previous studies available.

Abstract

Title: Experienced barriers and facilitators of researchers and nursing staff regarding Function Focused Care. A qualitative approach.

Background: The elderly are often physical inactive which can lead to a decrease in balance, muscle strength and quality of life. Nursing staff take over activities of elderly people most of the time leading to a decrease in activity and self-reliance. Function Focused Care is an approach to activate elderly and stimulate self-reliance. In the Netherlands various interventions have been developed according to Function Focused Care for different settings. For optimizing Function Focused Care it is important to gain insight into the barriers and facilitators, as experienced by researchers and nursing staff.

Research question: What are the experienced barriers and facilitators of researchers and nursing staff regarding Function Focused Care in nursing homes, home care and hospitals?

Method: A generic qualitative design was applied using focus group interviews with researchers and nursing staff guided by topic-lists. A thematic analysis was performed according to the six steps of Braun and Clarke.

Results: Four main themes emerged: nursing staff related barriers and facilitators, client related barriers and facilitators, organization related barriers and education related barriers and facilitators. These themes contain various barriers and facilitators, such as a lack of uniform working methods, refusal of clients to participate, time pressure, lack of support by management and facilitating training components.

Conclusions: This study has identified several barriers and facilitators related to Function Focused Care in the areas of nursing staff, clients, organization and education. Due to limitations, not all barriers and facilitators may have emerged in this study. Nevertheless, this study provides sufficient insights for optimizing Function Focused Care. Therefore, it is important to tackle emerged barriers and to deploy emerged facilitators when applying Function Focused Care.

Key words: *elderly, exercise, self-reliance, nursing staff, researchers.*

Samenvatting

Titel: Ervaren barrières en facilitators van onderzoekers en verplegend personeel met betrekking tot Function Focused Care. Een kwalitatieve benadering.

Achtergrond: Ouderen zijn vaak inactief, wat kan leiden tot verminderde balans, spierkracht en kwaliteit van leven. Verplegend personeel neemt meestal de activiteiten van ouderen over leidend tot een afname van bewegen en zelfredzaamheid. Function Focused Care is een aanpak voor het activeren van ouderen en stimuleren van zelfredzaamheid. In Nederland zijn verschillende interventies ontwikkeld volgens deze aanpak voor verschillende settingen. Voor het optimaliseren van Function Focused Care is het belangrijk om inzicht te krijgen in de door onderzoekers en verplegend personeel ervaren barrières en facilitators.

Onderzoeksvraag: Wat zijn de ervaren barrières en facilitators van onderzoekers en verplegend personeel met betrekking tot Function Focused Care in verpleeghuizen, thuiszorg en ziekenhuizen?

Methode: Een generiek kwalitatief design is toegepast, gebruik makend van focusgroep interviews met onderzoekers en verplegend personeel, begeleid door topic-lists. Een thematische analyse is uitgevoerd volgens de zes stappen van Braun en Clarke.

Resultaten: Uit de data kwamen vier hoofdthema’s: verplegend personeel gerelateerde barrières en facilitators, cliënt gerelateerde barrières en facilitators, organisatie gerelateerde barrières en educatie gerelateerde barrières en facilitators. Deze thema’s bevatten verschillende barrières en facilitators zoals gebrek aan uniforme werkmethodes, cliënten die deelname weigeren, tijdsdruk, gebrek aan ondersteuning door management en faciliterende trainingscomponenten.

Conclusies: Dit onderzoek heeft verschillende barrières en facilitators geïdentificeerd gerelateerd aan Function Focused Care op het gebied van verplegend personeel, cliënten, organisatie en educatie. Vanwege beperkingen van deze studie zijn mogelijk niet alle barrières en facilitators in dit onderzoek naar voren gekomen. Desalniettemin biedt dit onderzoek voldoende inzichten voor het optimaliseren van Function Focused Care. Daarom is het belangrijk om de gevonden barrières te verhelpen en de gevonden facilitators in te zetten bij het toepassen van Function Focused Care.

***Trefwoorden**: ouderen, bewegen, zelfredzaamheid, verplegend personeel, onderzoekers.*

Introduction

The majority of the elderly is often physical inactive[1-2-3-4]. Inactivity occurs in elderly people up to 80% of their daytime[1,5-6]. This inactivity can lead to a decrease in balance, muscle strength[2], and quality of life[3]. During moments of care, nursing staff can play a major role in the activity and self-reliance of elderly people in need of care. However, in nursing practice it appears that nursing staff take over the activities of daily living (ADL) (e.g. washing) and instrumental activities of daily living (IADL) (e.g. preparing food) most of the time[7]. As a consequence, these elderly become even more inactive. This puts the maintenance of underlying capabilities at risk which leads to functional decline and deconditioning[8]. As a result, the self-reliance of these elderly will deteriorate. It is of added value to reduce dependency and to maintain the current level of self-reliance as long as possible[9]. However, it can be challenging for nursing staff to motivate elderly to function more independently and to be more active[10].

An approach that allows nursing staff to motivate and activate elderly is called Function Focused Care (FFC) by Resnick et al. (2012)[8]. FFC can be described as a care philosophy focusing on the evaluation of individuals' underlying capability regarding daily and physical activity. It also aims to help these individuals to maintain and optimize functional abilities and increase time spent being physically active[8].

Internationally, various interventions have been developed based on FFC. A systematic review by Lee et al. (2019), including 22 studies conducted in nursing homes worldwide, described that FFC-interventions improve physical functioning, emotional balance, positive care interactions and benefits regarding to cognitive functions[11]. Less functional decline and maintaining function are positive findings as described by a literature review by Resnick et al. (2013), which included 20 studies in different settings[12]. Both reviews conclude the added value of FFC to improve functional abilities[11-12].

In the Netherlands, various interventions have been developed for the provision of care based on FFC; Stay Active at Home (SAAH) developed for home care[9], DAIly NURSE (DN) developed for nursing homes[13], and FFC-Hospital developed for hospitals (unpublished). The interventions differ in format and content since they were developed for three specific settings. All these interventions use the same philosophy and contain the components 'education', 'coaching', 'goal-setting' and 'policy', which are valuable components for an FFC-intervention[8].

In order to provide and optimise FFC, it is of value to know what helps nursing staff and what them prevents from working according to the FFC-philosophy. Researchers and nursing staff who have experience with FFC could provide insight into these barriers and facilitators.

Research question

What are the experienced barriers and facilitators of researchers and nursing staff regarding Function Focused Care in nursing homes, home care and hospitals?

Method

Design

A generic qualitative design[14] was applied by performing a secondary data analysis. Data from previous conducted focus group interviews with researchers and nursing staff were used to enhance our understanding of the experienced barriers and facilitators.

Population and setting

Participants of the focus groups were nursing staff and researchers who had experiences with FFC. Data collection took place with nursing staff from psychogeriatric wards of nursing homes of two healthcare organisations and from one home care team of one healthcare organisation, in the South of the Netherlands. Data collection from researchers took place with researchers from different parts of the Netherlands. Table 1 contains characteristics of the focus groups, including focus group numbers assigned for the current study.

Nursing staff were eligible for inclusion if they had experience with DN or SAAH. Researchers were eligible for inclusion if they were involved in the development or implementation of DN, SAAH or FFC-hospital. Participants of all focus groups were sampled in a convenience matter.

[Table 1]

Data collection

Focus group 1 was conducted in November 2018, focus group 2 in July 2017, focus group 3 in September 2017 and focus group 4 in March 2019. Focus groups 1-3 were part of process evaluations (unpublished data). Focus group 4 was held in preparation for development of a new FFC-intervention (unpublished data). Topic-lists were used for each focus group interview (Appendix 1-3). Although these topic-lists differ from each other, they are all mainly based on FFC literature of Resnick et al. (2012)[8] and literature aimed at successful implementation of Grol and Wensing (2017)[15]. Identifying barriers and facilitators regarding FFC was part of every focus group. Focus groups 1-3 were held at locations of healthcare organisations. Focus group 4 was held in a meeting centre. All focus group interviews were audio recorded and transcribed verbatim. Baseline characteristics were collected after the focus group interviews (age, gender, professional level, experience with

previous FFC-intervention. Solely from nursing staff: working hours, working experience. Solely from researchers: job description, previous education).

Data Analysis

A secondary data analysis was performed on data of focus groups 1-4. Data was thematically analysed according to the six steps of Braun and Clarke (2006) in order to identify important themes that emerge from the data[16]. Data analysis was supported by software package NVivo[17] version 12.

The first focus group interview was analysed independently by two researchers (SV+AK). First, the researchers repeatedly read the transcript separately in order to get familiar with the data. Memos were made for ideas of codes. Second, the researchers coded the data separately into meaningful segments, followed by comparing and discussing these segments. Third, these codes were categorised into themes and subthemes by the two researchers separately, forming a thematic map. Fourth, the researchers compared and reviewed the (sub)themes together. All segments belonging to a theme were reread to investigate if they formed a coherent whole. By consensus, some changes were made to the (sub)themes, as a result of which the thematic map was adapted. Fifth, the themes and subthemes were defined and named.

The other focus group interviews were similarly analysed by one researcher (AK). Constant comparison was applied during this process. Every time after coding and categorising a new focus group these codes and themes were compared with the already existing (sub)themes[18]. Themes and subthemes were adapted several times during this process. As a sixth step, the researcher reported the findings and supported them by quotes from the original data, which helps to establish the credibility of the described themes[18] (AK). The results presented do not indicate in which focus group the findings emerged since this has no added value regarding the research question and its answer. Quotes were indicated with a participant number (researchers: R1, R2..., nursing staff members of home care: H1, H2..., nursing staff members of nursing homes: N).

Baseline characteristics were analysed using the Statistical Package for the Social Science 24[19](AK).

Trustworthiness

A number of activities were undertaken in order to increase the trustworthiness of this study.

For increasing credibility member checking was applied in all focus groups, by summarizing the results in focus groups, or afterwards by email. Subsequently, participants were able to indicate whether the interpretation of their perspective was correctly portrayed[18].

Furthermore, data triangulation[18] was used by examining the perspectives of participants from three different settings and including nursing staff as well as researchers. Additionally, the credibility of the analysis was enhanced through researcher triangulation by the independent analysis of the first focus group interview by two researchers[14]. Also, all steps were peer-reviewed by a second researcher (SZ)[18].

For increasing confirmability an 'audit trail' was kept containing all steps taken, all notes made, all correspondence and all decisions made. This contributes to the objectivity of the research by providing insight into how findings and conclusions were reached[18]. Throughout the study memos were made of ideas, thoughts, impressions and evaluations. These memos contribute to the quality of the study and were helpful for reporting the results[14]. The consolidated criteria for reporting qualitative research (COREQ) checklist was used for improving the quality of reporting, the understanding of design, conduct, analysis and results and increasing the reproducibility of this study (appendix 4)[20].

Ethical issues

The primary studies were conducted according to the principles of the Helsinki Declaration, version October 2013[21]. The "Medical Research Involving Human Subjects Act" did not apply to this study because of the use of secondary data[22]. All personal data was handled complying with the Dutch Act on Implementation of the General Data Protection Regulation[23]. Tracible data were deleted from transcripts and replaced by codes (R1, R2…). Participants were approached by email. Written informed consent was obtained in focus groups 1-3. Verbal informed consent was obtained in focus group 4.

Results

No baseline data were available from the participating nursing staff of nursing homes. The characteristics of the participating nursing staff members of home care and researchers are presented in table 2 (nursing staff n=10, researchers n=7). The focus groups interviews lasted 58-137 minutes (mean 94 minutes).

[Table 2]

Four main themes emerged from the data: Nursing staff related barriers and facilitators, Client related barriers and facilitators, Organization related barriers and Education related barriers and facilitators. A thematic map was composed of the emerged themes and sub-themes (figure 1).

[Figure 1]

Nursing staff related barriers and facilitators

Lack of uniform working methods. Several participants mentioned the lack of uniform working methods of nursing staff as a barrier. They indicated that some colleagues took over the entire ADL of clients, while others encouraged clients to perform tasks themselves. Consequently, nursing staff stimulated clients to participate in FFC in varying degrees. Multiple nursing staff members mentioned that they were regularly unaware of the working methods of colleagues. This led to ignorance of the possibilities of clients, resulting in suboptimal performing FFC. According to several participants, the difference in working methods was partly due to goals not being specifically formulated in healthcare files. The goal did not clarify the capabilities of clients.

"..it says shower or ADL, then I think but it's a broad concept, so one says 'face and top he does himself', and the other says 'he can also do his legs and bottom himself'." (H6)

Multiple participants mentioned the attitude of some nursing staff members as a barrier for performing FFC. These staff members only applied FFC when they were addressed. Sharing experiences in practice and during team meetings was experienced as facilitating. This allowed nurses to learn from each other and to be able to use uniform working methods leading to a better application of FFC by all team members.

Competent coaching-on-the-job. The use of coaches-on-the-job was applied in nursing homes and hospitals. Various participants indicated that the use of competent coaches-on-the-job contributed to a proper application of FFC. These coaches motivated colleagues in applying FFC and conducted bedside-teaching. Furthermore, colleagues could contact them with questions and uncertainties regarding FFC. Being competent as a coach was seen as a requirement. In some cases, the coach-on-the job was appointed by the team leader, without opting for this. In those cases this person did not function as a coach and then having a coach-on-the-job had no added value.

"We had some really good people [coaches-on-the-job] who actually took over and then you see that it goes much better in practice, and we had some people who did not show informal leadership and then you see that on the ward it remained my [researcher's] thing." (R6)

Client related barriers and facilitators

Refusal of participation. Several participants identified the refusal of clients to participate in FFC as a barrier. Various reasons for this refusal of clients were mentioned. Such as lack

of knowledge of clients and family members regarding the benefits of FFC which led to non-acceptance. Also, when clients have received care for a long time, it was experienced as difficult to stimulate these clients in participating FFC. Participants indicated that these clients did not accept changes. Some clients or family members considered it the nurses' job to take over all activities of care.

"Like, 'well I don't have to do anything anymore, the nurse does it'." (H3)

A few participants stated that some clients in home care were afraid of losing hours of care when performing more tasks independently. This prevented these clients from participating in FFC.

Motivating activities. A facilitating factor indicated by various participants was setting goals together with clients. By involving clients, their interests were taken into account. Consequently, the motivation of clients to participate in FFC increased. Home care clients have been given an exercise booklet. Several clients mentioned to nursing staff that they regularly carried out exercises independently. Participants noted that these clients became more motivated to participate in FFC.

Organization related barriers

Time pressure. Many participants identified time pressure as a major barrier to execute FFC. Due to time pressure, many participants did not experienced time to let clients perform activities themselves and consequently took over these activities. Time pressure also hindered many to be consciously involved in FFC. Some participants mentioned that FFC was (partially) not applied in the event of staff shortage.

"You have an overcrowded route, you know that people have to be cared for at a certain time and then you soon tend to say let me do it, when they should do it themselves." (H4)

A few participants mentioned that by setting priorities and shifting tasks to a different time of day, time pressure could be reduced. Time pressure was also partly indicated as a feeling, which one can release more easily than the other. Some participants of nursing homes experienced more time pressure during physical care than during meals.

Lack of support by management. Some participants stated that management must actively motivate and facilitate nursing staff for FFC to be successful. Several participants did not feel sufficiently supported by management. They emphasize that management should

facilitate them more in terms of time and staff for providing FFC. Some experienced it as a barrier that management did not offer interest or support when implementing FFC. Consequently, nursing staff was uninformed, resulting in not seeing the importance of FFC nor knowing how to apply it correctly.

"It [FFC] comes to the workplace and you can figure it out yourselves, get started.. we sometimes get that feeling." (H4)

Some participants mentioned that clients were not sufficiently informed by management prior to the implementation of FFC. As a result, some clients refused to participate in FFC. Several participants mentioned ambiguities in exercise policy. Frequently, there were various policy documents, which were look alike, but did not contain matching information. Participants expressed this was causing uncertainties in the execution. A few participants were not aware of the existence of the organization's exercise policy.

Hindering environment. Many participants frequently saw the physical environment as a barrier for stimulating clients in self-reliance and ADL. For example a kitchen which was too small to let clients help, a toilet in a corner resulting in clients being incapable of using the toilet independently, a lack of assistive devices which prevented clients to perform tasks independently.

Education related barriers and facilitators

Limited preconditions. Nursing staff were offered workshops and practical assignments in varying degrees. Two hours of workshops were planned for participants of FFC-hospital. Participants identified this minimum available time as a barrier. Two hours was too short to create awareness and behavioural change in nursing staff which is necessary for applying FFC.

In some nursing homes, only coaches-on-the-job participated in workshops. These coaches mentioned not training the entire team as a barrier. They often experienced difficulties in motivating colleagues who were not trained, to apply FFC. Some participants stated that those who had not received the training did not perceive the intervention as structural.

"Sometimes it was also difficult to get someone on board. He then had a certain view of how things should be done and then it was sometimes difficult to state: 'we do it this way'." (N)[*]

[*] Participants of nursing homes were only indicated with the letter N, because their voices were indistinguishable.

Facilitating training components. During workshops practical assignments were handed out and discussed. Various participants experienced these assignments as a facilitating factor for it contributed to awareness. The assignments had to be performed with clients. Participants stated that these practical assignments helped involving clients in FFC.

In general, all participants experienced the content of the workshops as positive. Many expressed the improvement of their communication skills through the workshops, which enabled them to explain FFC to clients in a better manner. Nursing staff mentioned that the workshops enabled them to provide feedback aimed at performing FFC to each other more easily. Many also noticed that this feedback was now more easily accepted leading to a better application of FFC. All participants appreciated practicing with an actor in de workshops. As a result, their conversational skills improved which enabled them to inform clients about the added value of FFC in a better way, increasing the motivation of clients to participate in FFC. In the DN workshops, videos made during breakfast moments were shown. Many participants mentioned that this increased awareness. Seeing themselves performing care activities and getting feedback from each other enabled them to apply FFC in a better manner.

“The videos (…) that it’s very positive to see what you actually do and what could possibly be done differently. And that everyone has been more aware of this.” (N)

In DN, workshops focused mainly on performing FFC during breakfast moments. Because of this, some participants mentioned having difficulties in applying FFC during other moments of care.

Discussion

This study examined experienced barriers and facilitators of researchers and nursing staff regarding FFC. Main barriers included a lack of uniform working methods of nursing staff and refusal of clients to participate in FFC. The findings also showed that most participants mentioned time pressure as a major barrier that prevented nursing staff to use FFC. Additionally, various participants indicated an unclear policy and a lack of motivating and informing nursing staff regarding FFC by management as a barrier for performing FFC.
In general, the workshops were experienced as positive. Specific components, such as practicing with an actor, were identified as promoting for improving conversational skills and raising awareness for the purpose of performing FFC.

Barriers identified in the current study, such as time pressure, insufficient support, attitude of nursing staff and refusal of clients, correspond with findings of previous studies by

Benjamin et al. (2014)[24] and Resnick et al. (2008)[25]. Differences have been identified in client related barriers (e.g. syndromes, pain)[24-25]. Such barriers did not emerge in the current study. The fact that other client related barriers occurred in previous studies may be related to differences in the samples that were included in the studies. In the current study several barriers and facilitators emerged related to education regarding FFC (e.g. limited preconditions for education). Benjamin et al.[24] did not identify education related barriers or facilitators in their study. This is probably due because they focused on barriers in practice. However, effective education is of great importance for proper implementation[15]. Proper implementation of FFC is important for an adequate application of FFC in clinical practice for this leads to improvement in care provision. Therefore, the barriers and facilitators identified in FFC are of significant importance since these factors have a major influence on the implementation process of an intervention[15] (such as FFC).

A strength of this study to establish validity is the use of data triangulation[18] by examining the perspectives of participants from three different settings and including participants from different backgrounds (researchers and nursing staff). Additional strengths of this study for increasing the trustworthiness are the individual analysis of two researchers at one focus group interview, keeping an audit-trail, using the COREQ-checklist[20] and analysing according to the steps of Braun and Clarke[16].

A limitation related to the method used in the study is the secondary data analysis. The content of the data is linked to the objectives of the primary studies. Use of data from these primary studies made it impossible to adjust the topic-list for the subsequent focus group interview to clarify ambiguities that emerged in previous focus group interviews. This may have limited the richness of the data. Data saturation was not achieved in the original studies, meaning that not all concepts relevant to this study have been identified[18]. Consequently, certain important barriers and facilitators may not have emerged. This study has nonetheless provided ample barriers and facilitators which can contribute to optimize the application of FFC. Another limitation of this study is the lack of the perspectives of clients. Clients were not included due to difficulties in interviewing them. The participating researchers and nursing staff were not fully able to reflect the perspectives of clients. The clients' perspective is important for optimizing FFC, as shown in the results. The results indicate that including interests and perspectives of clients (as in goal setting) contributes to optimizing FFC. Therefore, further research is necessary to investigate the experienced barriers and facilitators of clients. New insights may arise from this that can further improve the application of FFC.

The transferability of this study is mediocre. Despite the use of data triangulation that includes different settings, not all settings were sufficiently represented. Within nursing homes, only psychogeriatric wards were included. In home care only one single care team

was included. This limits the transferability of this study. In addition, no baseline data was available from nursing staff members of nursing homes, making it difficult for nursing homes to determine whether results apply to their own wards[20].

This study provides various implications for clinical practice. Participants indicated the lack of uniform working methods as a barrier. According to them, the cause of this was that goals were unclear and that nursing staff did not share their experiences with each other resulting in colleagues' ignorance about the capabilities of clients. A number of practical implications follow: setting achievable and specific goals, discussing difficulties and experiences regarding FFC in team meetings and using a coach-on-the-job who is able to provide clear information and feedback. These implications correspond to strategies recommended by Grol and Wensing (2017) for improving the execution of an intervention[15], such as FFC. Conversational skills of nursing staff must be improved for informing and motivating clients to participate in FFC. For improvement of these skills it is valuable to include the facilitating training components that have emerged in this study as part of FFC-education. Optimizing FFC requires management to facilitate in time and staff. They also need to inform and actively motivate nursing staff in applying FFC. In addition, management must ensure a clear and unambiguous policy with regard to FFC and actively inform nursing staff of this policy.

Conclusion

This study has identified several barriers and facilitators related to FFC in the areas of nursing staff, clients, organization and education. Due to limitations, such as performing a secondary data analysis and not including clients in the focus groups, not all important barriers and facilitators may have been emerged in this study. Nevertheless, this study provides sufficient insights for optimizing FFC.

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TABLES AND FIGURES

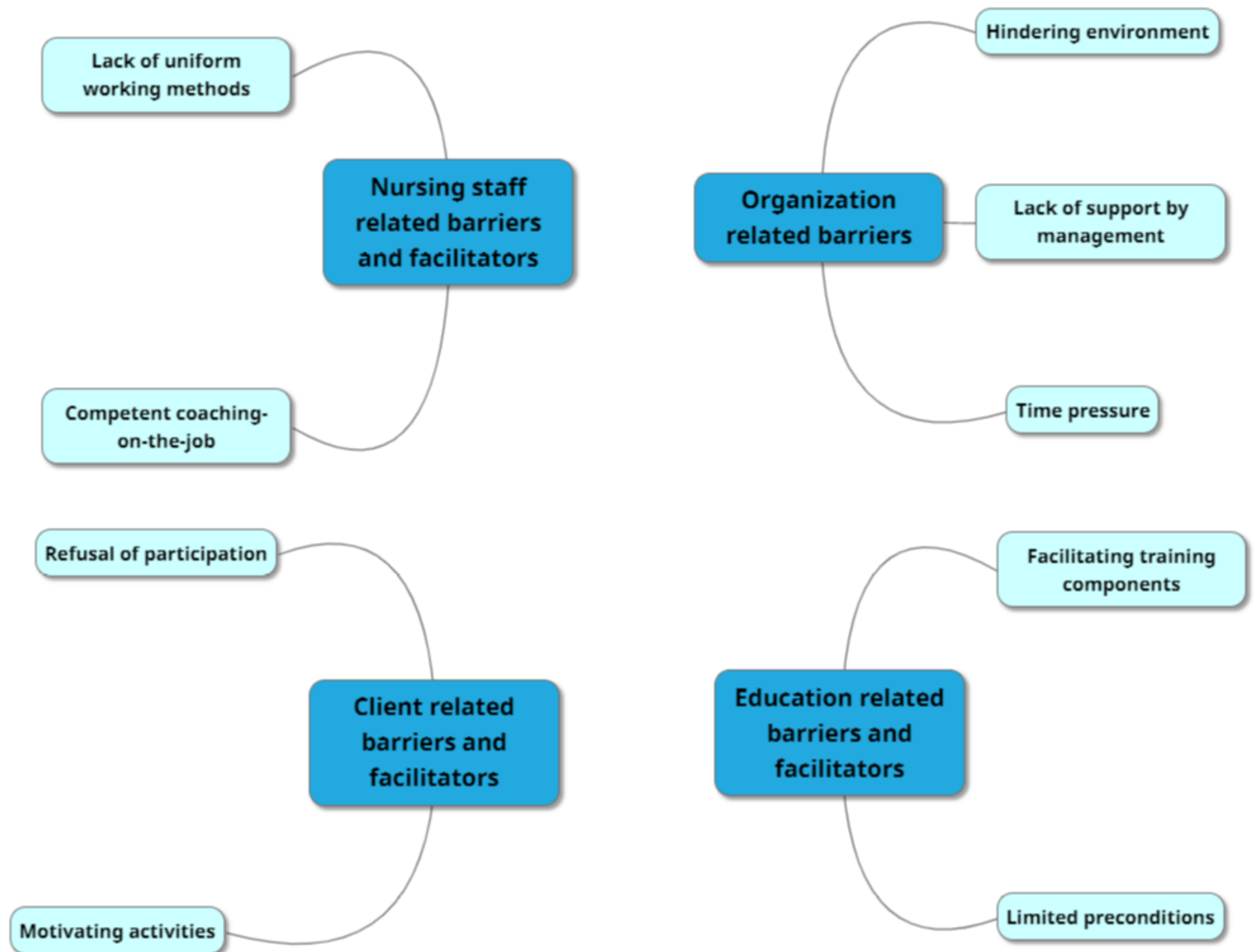
Table 1: characteristics of focus group interviews

Focus group number	*Participants*	*Setting*	*FFC-intervention*	*Origin data*
1	Nursing staff	Home care in the south of the Netherlands	Stay Active at Home	Focus group interview from a process evaluation (unpublished)
2	Nursing staff	Psychogeriatric wards of nursing homes in the south of the Netherlands	DAIly NURSE	Focus group interview from a process evaluation (unpublished)
3	Nursing staff	Psychogeriatric wards of nursing homes in the south of the Netherlands	DAIly NURSE	Focus group interview from a process evaluation (unpublished)
4	Researchers	Nursing home, home care and hospital in different parts of the Netherlands	DAIly NURSE, Stay Active at Home, FFC-hospital	Expert-meeting in preparation for the development of a new generic FFC-intervention (unpublished)

Table 2: Baseline characteristics of participants of focus group 3 and 4 (n=17)

Age in years (mean, SD)	39 (11)
Gender (n)	
Female	16
Male	1
Professional level (n)	
Vocationally trained registered nurses	2
Certified nurse assistant	6
Care assistant	2
Scientifically educated	7
Experience with previous FFC-intervention (n)	
Stay Active at Home	12
DAIly NURSE	4
FFC-Hospital	2
Working hours per week of nursing staff (mean, SD)	21 (8)
Working experience in elderly care in years of nursing staff (mean, SD)	21 (11)
Job description of researchers (n)	
Researcher	2
Research assistant	1
PhD student	2
University lecturer	1
Policy officer	1
Previous education of researchers (n)	
Bachelor educated nursing	3
Physiotherapy	1
Psychology	1
Epidemiology and Public Health	1
Human Movement Science	1

Figure 1: thematic map



Appendix 1

Topic-list focus group 1 and 2 (DAIly NURSE)

Education

• Did you follow the education program?

• What is your impression of the workshops? What was the strongest component?

• Did the workshops focused to much on breakfast instead of ADL and HDL?

• Was there too much repetition in the workshops? Can you give an example of this?

• Is it good or bad to combine several wards in the workshops?

• What caused messiness during the workshops?

• What has changed in stimulating the activities and self-reliance of residents? What caused this change?

• Do you see changes among the residents? What has changed? Are these changes permanent?

Policy

• What does the exercise policy entail?

• How were you informed about the exercise policy? Was this enough to clarify everything about DAIly NURSE?

• How are you supported by the exercise policy?

• Do you feel sufficiently supported by management for applying the intervention in practice?

• Are peer review meetings planned (how often and with whom)?

• What agreements have been made about stimulating exercise (exercise policy)? How were you informed about this and how (often) are these agreements evaluated?

• Is this actually carried out in practice?

• Is exercise a recurring theme in team meetings?

Coaching

• You indicated in the questionnaire that you were satisfied with the workshops and the trainer of the workshops. What is the reason for this?

• How is the coaching applied in practice ? How are you deployed as a coach-on-the-job?

• Do you, as coaches, have other meetings regarding DAIly NURSE besides the peer review meetings?

• Participants who are not assigned as coach: how did you experience the coaching of the coaches-on-the-job and of the specialized nurse? Did you receive feedback during workshops / work?

• How often do you give feedback to colleagues and consult the specialized nurse? Are other professionals also involved in this? Do you have enough information to provide feedback?

General

• To what degree are you satisfied with the intervention?

• How could the intervention be improved?

• What are the barriers and facilitators of the intervention for stimulating daily activities and self-reliance of residents?

• Are there other changes that have occurred in the wards that can affect the results? Are multiple projects running?

Appendix 2

Topic-list focus group 3 (Stay Active at Home)

Topic

1. What did you think of the Stay Active At Home program?

2. What have you learned from the Stay Active At Home program?

3. What did you like the most about the Stay Active At Home program (which was positive), and what did you dislike most (which was less positive)?

4. What do you need to clarify the Stay Active At Home program?

5. To what extent did you use the Stay Active At Home program in practice? / What have you changed in the way you provide care compared to the way you provided care before the start of the program, and why have you changed it? And what changes have you observed within your colleagues?

6. What are your experiences with the Stay Active At Home program in practice?

7. What has helped / stopped you from applying the Stay Active At Home program in practice?

8. How do you want to continue to apply the Stay Active At Home program, and what do you need for this?

Appendix 3

Topic-list focus group 4 (researchers)

- How are the 4 FFC components as designed in the executed studies conducted in the different settings?
- What are the researchers' experiences with the implementation of the different components in the executed studies conducted in the different settings?
- What are the experienced barriers and facilitators of the researchers with regard to the executed studies conducted in the different settings?
- Which adjustments would be needed to develop a generic approach to FFC?

Appendix 4

Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

No	Item	Guide questions/description
Domain 1: Research team and reflexivity		
Personal Characteristics		
1.	Interviewer/facilitator	Which author/s conducted the interview or focus group?
2.	Credentials	What were the researcher's credentials? *E.g. PhD, MD*
3.	Occupation	What was their occupation at the time of the study?
4.	Gender	Was the researcher male or female?
5.	Experience and training	What experience or training did the researcher have?
Relationship with participants		
6.	Relationship established	Was a relationship established prior to study commencement?
7.	Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. *personal goals, reasons for doing the research*
8.	Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? e.g. *Bias, assumptions, reasons and interests in the research topic*
Domain 2: study design		
Theoretical framework		
9.	Methodological orientation and Theory	What methodological orientation was stated to underpin the study? *e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis*
Participant selection		
10.	Sampling	How were participants selected? *e.g. purposive, convenience, consecutive, snowball*
11.	Method of approach	How were participants approached? e.g. *face-to-face, telephone, mail, email*
12.	Sample size	How many participants were in the study?
13.	Non-participation	How many people refused to participate or dropped out? Reasons?
Setting		
14.	Setting of data collection	Where was the data collected? e.g. *home, clinic, workplace*
15.	Presence of non-participants	Was anyone else present besides the participants and researchers?
16.	Description of sample	What are the important characteristics of the sample? *e.g. demographic data, date*
Data collection		
17.	Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?
18.	Repeat interviews	Were repeat interviews carried out? If yes, how many?
19.	Audio/visual recording	Did the research use audio or visual recording to collect the data?
20.	Field notes	Were field notes made during and/or after the interview or focus group?
21.	Duration	What was the duration of the interviews or focus group?
22.	Data saturation	Was data saturation discussed?
23.	Transcripts returned	Were transcripts returned to participants for comment and/or correction?
Domain 3: analysis and findingsz		
Data analysis		
24.	Number of data coders	How many data coders coded the data?
25.	Description of the coding tree	Did authors provide a description of the coding tree?
26.	Derivation of themes	Were themes identified in advance or derived from the data?
27.	Software	What software, if applicable, was used to manage the data?
28.	Participant checking	Did participants provide feedback on the findings?
Reporting		
29.	Quotations presented	Were participant quotations presented to illustrate the themes / findings? Was each quotation identified? e.g. *participant number*
30.	Data and findings consistent	Was there consistency between the data presented and the findings?
31.	Clarity of major themes	Were major themes clearly presented in the findings?
32.	Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?