

2023

## A multi-stakeholder perspective on quality of care among residents, family members and nursing staff in nursing homes: A Balanced Centricity approach

Sil Aarts

*Department of Health Services Research, CAPHRI Care and Public Health Research Institute, Maastricht University*

Erica De Vries

*Department of Health Services Research, CAPHRI Care and Public Health Research Institute, Maastricht University*

Hilde Verbeek

*Department of Health Services Research, CAPHRI Care and Public Health Research Institute, Maastricht University*

Gaby Odekerken

*Department of Marketing and Supply Chain Management, SBE School of Business and Economics, Maastricht University*

Katya Y. J. Sion

*Department of Health Services Research, CAPHRI Care and Public Health Research Institute, Maastricht University*

Follow this and additional works at: <https://pxjournal.org/journal>



Part of the [Geriatric Nursing Commons](#)

### Recommended Citation

Aarts S, De Vries E, Verbeek H, Odekerken G, Sion KY. A multi-stakeholder perspective on quality of care among residents, family members and nursing staff in nursing homes: A Balanced Centricity approach. *Patient Experience Journal*. 2023; 10(2):148-156. doi: 10.35680/2372-0247.1809.

This Research is brought to you for free and open access by Patient Experience Journal. It has been accepted for inclusion in Patient Experience Journal by an authorized editor of Patient Experience Journal.

---

## **A multi-stakeholder perspective on quality of care among residents, family members and nursing staff in nursing homes: A Balanced Centricity approach**

### **Cover Page Footnote**

The researcher would like to thank all participants. This research was funded by the long-term care organizations within the Living Lab in Ageing and Long-Term Care, the health insurance fund CZ (201600132) and ZonMw (639003908).

# A multi-stakeholder perspective on quality of care among residents, family members and nursing staff in nursing homes: A Balanced Centricity approach

Sil Aarts, *Maastricht University*, [s.aarts@maastrichtuniversity.nl](mailto:s.aarts@maastrichtuniversity.nl)

Erica De Vries, *Maastricht University*, [erica.devries@maastrichtuniversity.nl](mailto:erica.devries@maastrichtuniversity.nl)

Hilde Verbeek, *Maastricht University*, [h.verbeek@maastrichtuniversity.nl](mailto:h.verbeek@maastrichtuniversity.nl)

Gaby Odekerken, *Maastricht University*, [g.odekerken@maastrichtuniversity.nl](mailto:g.odekerken@maastrichtuniversity.nl)

Katya Y. J. Sion, *Maastricht University*, [k.sion@maastrichtuniversity.nl](mailto:k.sion@maastrichtuniversity.nl)

## Abstract

The objective of this study was to use a Balanced Centricity (BC) approach to describe how personal values related to experienced quality of care are defined for residents, family and nursing staff in nursing homes. Capturing the values from a multi-stakeholder perspective, a qualitative approach was conducted in which the stakeholders' (e.g., residents, family members of residents and nursing staff; a triad) experiences, opinions and values were explored. Participants were recruited from ten nursing homes within the Living Lab in Ageing & Long-Term Care Limburg, the Netherlands. The audio recording of every interview was transcribed verbatim. The analysis made use of an inductive and deductive approach. In total, 12 individuals were interviewed in 4 triads. Three main values were identified throughout the triads: greater focus on wellbeing, feelings of autonomy and family matters. All stakeholders mentioned the need for a greater focus on well-being in which more one-on-one time (i.e., between one resident and a staff member) is possible. However, discrepancies in the values between these three stakeholders are also present in topics such as autonomy and the role of family visits. This study underscores that, although several values are aligned between these stakeholders, other values display discordance. Especially in a setting as complex as nursing homes, a BC approach might be considered in which not only the values and needs of residents, but also those of their family members and nursing staff are taken into consideration.

## Keywords

Patient experience, quality of care, nursing homes, resident perspective, balanced centricity, values.

## Background

Nursing homes are complex, dynamic care environments for some of the most vulnerable people in our society. The nursing home sector has shifted towards a more person-centered approach, in which the role of the care receiver, i.e., the resident, is the starting point<sup>1</sup>: focus is on residents' preferences and values. Residents have expressed the importance of feeling alive, the need for a home-like environment, person-centered care tailored to their specific wishes, and the need for autonomy.<sup>2</sup> In nursing homes, often a network of stakeholders is present to create value.<sup>3</sup> For example, residents' quality of life and quality of care depend not only on their interactions with nursing staff but also on their interactions with family and volunteers.<sup>4,5</sup> Because of this diverse and complex network of stakeholders, a multi-stakeholder focus is needed, in which also the preferences and values of other important stakeholders are included.<sup>6,7</sup> In doing so, value can be created for not only residents,

but for all stakeholders who have a profound role in nursing homes.<sup>8</sup>

## Theoretical framework

In 2007, Gummesson introduced the term *Balanced Centricity*, describing a situation in which all included stakeholders' interests are fulfilled.<sup>9</sup> This term, introduced in service research, claims that a customer-centered approach may be too limited; it diminishes that, apart from the customer, a diverse network of stakeholders is involved. Hence, Balanced Centricity highlights a need to consider values of multiple stakeholders. Each stakeholder within the network benefits from the actions of another stakeholder. Balanced Centricity proposes that all stakeholder's roles are fundamental in order to, in combination, co-create value. It is suggested that the inclusion of a variety of stakeholders is the only way to balance needs, increase consensus and benefit from transparency.<sup>3</sup> However, when stakeholders have

competing interest, the well-being of one stakeholder might decrease the levels of well-being of another, consequently diminishing the well-being of the entire network.<sup>10</sup>

In nursing homes, besides nursing staff, family members of residents also play an important role; their presence is required for residents' well-being. If various stakeholders in nursing homes have a shared understanding of the necessity of shared value and how to define and co-create value, necessary steps towards the fulfillment of all stakeholders' value can be postulated. Hence, a Balanced Centricity approach might provide innovative insights to define and co-create value in care provision in nursing homes (i.e., an integration process involving various stakeholders that are linked within an ecosystem and who learn from each other's perspectives).<sup>11</sup> Residents, family and nursing staff each have different needs that add value to their daily lives. For example, residents have expressed the importance of feeling at home and being treated as individuals,<sup>2,12</sup> whereas family have highlighted the importance of the resident's physical appearance and focusing on how the resident's life was at home.<sup>13</sup> Nursing staff have expressed valuing their working environment not only in terms of resources, but also in terms of effective leadership and team dynamics.<sup>14</sup>

To co-create value, daily care provision should build on the needs and wants of all stakeholders and seek a balance instead of one dominant focus. Hence, when beneficial outcomes are created for all stakeholders involved, it is assumed that the value of the entire network of stakeholders increases. However, the consequences of discordance between stakeholders can also occur, for example when a resident likes to sleep in until ten o'clock while nursing staff might think that value is best created by bathing and dressing this resident as soon as possible. Although value isn't created by a single situation, this example illustrates the impact of discordance in the opinions and experiences regarding value.

As a nursing home setting comprises of a complex web of interactions among multiple stakeholders,<sup>3,15</sup> a Balanced Centricity approach might do justice to its complex nature. Although a number of studies explored a Balanced Centricity (especially focused on service research),<sup>7</sup> empirical research within a nursing home setting is absent. The purpose of this study was to use this approach to describe how the concept of value is defined for various stakeholders within a nursing home setting. By creating insights in the similarities, differences and possible conflicts regarding value, an in-depth view on how to co-create value in a nursing home setting can be formulated. Following a qualitative research approach, this paper presents the concept of Balanced Centricity within a case application including in-depth interviews about experienced quality of care from a multi-stakeholder

perspective including residents, their family and nursing staff.

## Methods

To capture the value of a Balanced Centricity from a multi-actor perspective, a qualitative study was conducted in which residents, their family and nursing staff's experiences with quality of care were explored. Semi-structured, in-depth interviews were conducted in 2019 as part of Connecting Conversations.<sup>16</sup>

### *Setting and participants*

Participants were recruited from ten nursing homes within the Living Lab in Ageing & Long-Term Care Limburg, the Netherlands.<sup>17</sup> In order to be included, residents had to live in a nursing home and receive long-term care; the family member was a contact person of the resident; the nursing staff member (hereafter called nurse) was involved in the residents' daily care provision on a regular basis. Further details on participant selection have been previously published.<sup>16</sup>

### *Data collection*

Connecting Conversations is a narrative method that assesses experienced quality of care in nursing homes from the resident's perspective.<sup>16</sup> Separate conversations are performed with a resident, family member and nurse: a triad. The conversations were performed by a staff member (hereafter called interviewer) employed in another care organization who received an interviewer training.

Connecting Conversations consists of six questions about the resident's experienced quality of care: quality of life, satisfaction with care providers, most positive experience in the nursing home, average day in the nursing home and relationships between the resident, family and nursing staff. These questions are based on the INDEXQUAL framework and henceforth incorporate the service science and health science perspective.<sup>18</sup> Family members and nursing staff were asked to answer the questions from the resident's perspective. After a participant gave written informed consent, the interview was audio-recorded. Details on the method have been published elsewhere.<sup>16</sup> The study was carried out in accordance with all relevant (ethical) guidelines and regulations. Ethical approval was provided by Zuyderland Ethics Committee (17-N-86 METC Zuyderland).

### *Interview selection*

In the current study, purposeful sampling was employed (SA, EdV & KS) to assure a variety in level of agreement between resident, family and nurse, and the degree to which the respondents were negative or positive about the quality of care. First, several overarching criteria were considered: 1) triads that were incomplete (e.g., no family available); 2) interviews including residents with (mild)

cognitive problems (e.g., because of the lack of in-depth answers) were excluded; and 3) to avoid overrepresentation of an interviewer or ward, the selected triads were performed by different interviewers on different wards.

Selection was based on the degree to which a triad was positive or negative and the degree of agreement between the resident-family-nurse. This assured a variety in the selected triads (see<sup>19,20</sup> for more information). More specifically, the researchers aimed to include both positive and negative triads with high and low agreement for two reasons. First, from a Balanced-Centrality approach, it is interesting to discover differences in perspectives regarding value. Second, discrepancies between the perspectives in a triad were found most interesting because of everyone's roles. Hence, one triad was selected in which participants were all positive (triad 4): one in which participants were all less positive (i.e., negative) (triad 1), one in which the resident was less positive than the nurse (triad 2); and one triad in which the resident was less positive than the family member (triad 3).

### **Data analysis**

Audio recordings of every interview were transcribed verbatim (n=12). The analysis made use of both an inductive and deductive approach. An inductive approach is focused on finding patterns in observations and theorizing these patterns. In contrast, a deductive approach starts with a theory and expected findings and analyses the data at hand to test this. Inductive and deductive approaches are often employed in congruence for a more complete understanding.<sup>21</sup>

### **Inductive approach**

Every transcript was first analysed using an inductive approach, to identify relevant fragments that could directly or indirectly provide an answer to what in the care process provided value to participants. For the coding process, the definition of value as postulated by Mazaroti (2017),<sup>22</sup> was used: "personalized care, where patient's expectations and needs are included in a holistic approach of medicine that considers physical, mental, and spiritual well-being."<sup>22</sup> With a qualitative approach, stakeholders' personal experiences were inductively explored and 'open coded' (i.e., open coding is also referred to as inductive coding<sup>21</sup>): all key fragments were summarized in a code that reflects the condensed meaning of that fragment. Open coding was conducted by two individual researchers (SA & EV). Initial codes were discussed by all researchers and altered or renamed if necessary. Afterwards, all codes were clustered (SA, EV & KS) based on similarity and grouped into themes (i.e., axial coding)<sup>23</sup>; the interpretation of the main themes were discussed with all researchers involved.

### **Deductive approach**

Afterwards, a deductive approach was used. Deductive research explores a known theory or phenomenon, in this case the Balanced Centrality approach, and tests if that theory is present in given circumstances. The themes from the inductive approach were analysed for shared or conflicting values among all four triads. This analysis was conducted by three researchers (SA, EV & KS). The quotes were translated from Dutch to English.

### **Findings**

In total, 12 individuals were interviewed. All residents were female (mean age 88 years; SD:4). Some residents were living in the nursing home for 6 months, others for several years (mean: 21 months; SD:15). Family members were two sons and two daughters (mean age 60 years; SD:4). All interviewed nurses were female (mean age 38 years; SD:6). They worked in long-term care between 7 and 26 years (mean: 17; SD:7).

Firstly, the themes per triad (the inductive approach) are listed. Secondly, the overall themes that are apparent from all the interviews (the deductive approach) are postulated.

#### **Triad 1**

The resident is an 86-year-old female who lives in the nursing home for 6 months. Her son, 62 years old, is her closest family member. The nurse is 47 years old with 26 years of working experience. All respondents are rather negative about the experienced quality of care and the need for the resident to have autonomy.

#### **Resident wants more attention, family and nursing staff find it sufficient.**

The resident mentioned she would like more attention: when she asks for help, the nursing staff isn't coming.

*"They say if there is anything you need, just call. But they just won't come. That is ridiculous."* (R1)

*"I know they don't have time. They come in, a bell rings and they leave immediately."* (R1)

The resident's son reported that staff is busy and are doing a good job in caring for his mother. He said she 'isn't an easy person' and often has to deal with her behavior.

*"She thinks that if you push the button, people will jump up right away to help her. I told her there are more people living here. [...] My daughters also tell her, they also work in long-term care, that she lives in a really nice place."* (F1)

*"Yes, it's heavy. I only hear her complain but I experience the care here differently. [...] As far as I can tell, the staff is doing their very best."* (F1)

The nurse reported knowing how the resident feels.  
“*She wants more time. More time and attention.*”

However, she feels the resident asks too much of her and she does enough. This sometimes frustrates her. She does state that the family understands her position.

“*I sometimes feel frustrated. It’s a pity that there is no understanding. You try to explain the situation and she pretends not to hear you.*” (C1)

The nurse mentioned to have a good relationship with the resident’s family. It makes her feel better to know that the family also knows how the resident sometimes can behave.

“*The family recognizes the things we have to deal with.*” (C1)

### **Family is appreciated**

The resident appreciates her family and likes them to visit, which is confirmed by the nurse.

“*I like it when he visits me every day. And he does.*” (R1)

On the contrary, family defines the relationship with the resident as a “*difficult one*.” Her son does visit often but sees this as an “*obligation*” rather than something that brings value to him.

“*She claims me, and I don’t always handle it well.*” (F1)

“*It’s hard for me to say as her son, but it feels like an obligation. But I don’t mind, I like to do things.*” (F1)

### **Having autonomy by not being among other people**

The resident describes herself as “*not a people person*.” She states she dislikes being among many people or to do activities with others.

“*No, they know. I told them, I have made it clear that I don’t like that. They can’t make me.*” (R1)

Family confirms this by mentioning that the resident is not a “*people-person*.”

“*She is people shy. She likes to be alone. And to change that is hard. And that’s the problem, the biggest problem.*” (F1)

The nurse reported that the resident doesn’t like to participate in activities (including eating) with many people around and often likes to be alone.

“*She wants to be on her own.*” (C1)

Additional agreements have been postulated for the resident. For example, dinners with just a few residents.

However, the nurse mentioned she keeps asking the resident to participate in activities or dinners, even though she knows the resident doesn’t like it.

“*The activity professionals have asked her multiple times, but she is not interested.*” (C1)

“*She is invited for everything in order to bring her more among other people, but you won’t do her any favors with that.*” (C1)

### **Triad 2**

The resident is an 89-year-old female, living in the nursing home for almost 4 years. Her 64-year-old son is her closest family member and the nurse is a 37 years old woman with 16 years of working experience in long-term care. All participants in this triad are rather positive about the experienced quality of care. The value of having time alone is mentioned and deemed important by all.

### **Pain influences daily life of the resident**

The resident mentioned that her pain, due to rheumatic arthritis, highly influences her daily life.

“*I am too weak to participate in activities.*” (R2)

When asked what she needs to improve her quality of life she said improvements in physical status: “*Just more strength. Too many times I fell.*” (R2)

Her son and nurse mentioned that they perceive the resident’s quality of life as low due to her physical problems.

“*I don’t know if we could do anything...she just has that pain and there is really nothing to do about it [...]*” (C2)

“*That [quality of life] is just not something that could be improved. She is just always in a lot of pain. [...] That is her big problem, I think.*” (F2)

### **Quality of daily care provision is good**

When the resident was asked what she values in the nursing home, she mentioned:

“*A lot of things. Food is fine. And with the girls [nursing staff], when something is the matter, you just call them [...] and they come.*” (R2)

Her son and the nurse rated the provided quality of care as high.

“*She often tells us that she is happy with the care she receives.*” (C2)

“*She is just very pleased with the care that is provided, and I think there is little that can be improved. Look, of course she would prefer,*

*so to speak, 24-hour personal guidance, but that is not realistic.”* (F2)

The nurse mentioned that the resident highly values a one-on-one talk or activity, and the frequency thereof could be increased.

*“She just really likes one-on-one time. Just go for a walk with her. Or just have a talk with her [...] I think just more time to talk with her. She likes that.”* (C2)

### **Resident values her autonomy to have time alone**

The nurse stated that the resident likes to be by herself. *“If you ask her what she wants to do and she tells me she doesn’t want to do [...], she just wants to stay in her room.”* (C2)

Her son confirmed this claim.

*“Even when she was living at home, when my dad was still alive, this was the case. She just loves to be home, watch television or read. What I mean is, she just likes to be by herself.”* (F2)

The resident mentioned that her family pays regular visits. She highly values her children and grandchildren. Her room contains several pictures of them.

*“I love it when they visit. Especially on Sunday when they bring the grandchildren.”* (R2)

Her son confirms that the visits and pictures are very important to his mother. In addition, the nurse mentioned that family visits regularly and makes special efforts such as decorating her room on special occasions.

*“I have enough contact with my mother, I wouldn’t want to change anything. I mean, if she is in a bad mood, I accept this and sometimes I do say that if she is being like that, it’s not very nice to visit her. For the rest, all is okay.”* (F2)

### **Triad 3**

The resident is an 83-year-old female who has lived in the nursing home for almost a year. Her 54-year-old daughter is her most involved family member; the nurse is a 30 years old woman with 7 years of working experience. The resident seems quite negative about the experienced quality of care (i.e., regarding washing), whereas the family and nurse are quite positive.

### **Quality of daily care provision is good**

All three participants reported to highly value the care service that is provided.

*“We get food and drinks all day long, and every wish comes true, she [the resident] says. And it really is true.”* (F3)

The resident and her daughter did mention one important point regarding care provision. The resident values to not be washed while sitting on the toilet.

*“You need to sit on the toilet to be washed.”* (R3)

*“She has a problem with having to be washed sitting on a toilet. She thinks that is gross.”* (F3)

*“It is sometimes difficult to give every resident what he or she wants. You take over very quickly, while it is not always necessary. [...] If it takes someone 5 minutes to wash one arm, we can do that much faster.”* (C3)

### **More attention for wellbeing**

More attention, in terms of an extra talk for example, was mentioned as a prerequisite for improving value.

*“Sometimes if you are in a bit of a hurry and she [the resident] is less able to handle that. She gets quiet.”* (C3)

*“She likes it if something beautiful is selected from her wardrobe. She finds that important. Some nurses see that, but not everyone.”* (F3)

*“Sometimes it is more difficult to get away from a resident, you find it annoying to cut them off.”* (C3)

### **Triad 4**

The resident is a 93-year-old female, living in the nursing home for two years. Her 58-year-old daughter is closely involved in her care, and the nurse is a 38 years old woman with 17 years of working experience. All three respondents are rather positive about the experienced quality of care. Both the resident and the family member value the visits. However, family also mentioned to feel claimed sometimes.

### **Quality of care can be improved**

All respondents express their overall gratitude and satisfaction regarding the quality of care. The resident mentions her values are being met, as the nursing staff does everything she asks for.

*“I am well looked after here.”* (R4)

Her daughter also reports a critical note:

*“Sometimes those ladies [nursing staff] go outside to smoke. That’s fine, but then there are a few ladies [residents] and no one helps them. It’s not up to me to help them.”* (F4)

In addition, she mentions that the communication between nursing staff is a value that needs to be improved.

*“A lot of ladies work here. You talk to one today but then tomorrow there will be another who knows nothing about it [the talk].”* (F4)

When the nurse is asked what might be improved, she would value more staff in the morning hours.

*“It is busy. It would just be nice to start the day with two [nurses] per ward.”* (C4)

### **Recognition for daughter’s involvement**

Both the resident and nurse appreciate the time and effort spent by the daughter. The resident also reports to fully understand that she has more things to do than only visiting the nursing home.

*“Yes, I would prefer [her visiting] every day, but that is difficult, I understand that too. She also has a life.”* (R)

In sharp contrast, the daughter expresses she does not always feel appreciated by her mother.

*“She claims me. I always had to report to [to the resident]: where are you? What’s taking you? I always got this whole load.”* (F)

### **Overarching values apparent from the triads**

Three main values were identified in the triads: 1) greater focus on well-being, 2) feelings of autonomy, and 3) family matters.

#### ***Theme 1: Emphasis on well-being***

A strong balance in the value of quality of care (i.e., basic care delivery) was apparent: quality of care was perceived as positive by all but one interviewee (one resident was less positive). In sharp contrast, all interviewees mentioned the need for a greater focus on well-being. Things like more “1-on-1 time” and “time for an extra chat” (between the residents and nursing staff) were highly valued by all stakeholders. Interestingly, this is confirmed by nursing staff; they mention to highly value ‘quality time’ with individual residents. However, often a disbalance in this value exists, since nursing staff mentioned that the pressure of their work often makes it impossible to spend more one-on-one time: “Time for an extra chat would be nice. One day it is possible, but that’s not always the case. That’s a shame.”

#### ***Theme 2: Feelings of autonomy***

Residents’ autonomy was an often-mentioned value in all interviews. Residents and their family members all reported they feel they have a say in how they spend their day; they report this as a valuable asset of living in a nursing home. For example, if certain foods are asked for or if a resident wants to sleep in, this is often made possible. However, nursing staff reported that time constraints often create a disbalance in this value. This

hinders providing the resident with more autonomy, for example when helping residents with washing: “It is sometimes difficult to give every resident what he or she wants. You take over very quickly, while it is not always necessary. If it takes someone, for example, 5 minutes to wash one arm, we can do that much faster”.

#### ***Theme 3: Family matters***

A strong balance in valuing the family’s role was apparent in all interviews. Residents mentioned they highly value their visits, including visits from grandchildren. The family themselves also mentioned they value these visits. Some residents expressed the desire to be visited by their family on a daily basis, although they also reported that their children have their ‘own lives.’ However, a disbalance in this value exists as some family report to experience pressure to visit ‘their’ resident and sometimes even see it as an ‘obligation.’ Nursing staff highly values the presence and help from family members: “She is very helpful. She helps every Tuesday with cleaning up and can stay for dinner.” They also reported they highly value the honesty and feedback from family members: “When something is wrong or can be improved, she will tell us.”

### **Discussion**

This study aimed to gain insights into the similarities, differences and possible conflicts regarding value created in a nursing home from a multi-stakeholder perspective. A Balanced Centricity approach was used to study values of residents, family members and nursing staff regarding quality of care. Results identified three important themes: 1) greater focus on well-being, 2) feelings of autonomy, and 3) family matters.

All stakeholders mentioned the need for a greater focus on well-being in which one-on-one time between a resident and nurse was deemed important. This suggests that more time is needed to focus on residents’ well-being to create a balance between the values of all stakeholders. This goes beyond basic care tasks such as washing and eating. This finding is underscored by previous research suggesting that nursing staff often feel they lack time for socially interacting with residents.<sup>24,25</sup> Nursing staff often do not perceive the time they spend on basic care tasks as ‘quality time’ with their residents. However, especially during these tasks, interaction between a resident and nurse can be of utmost importance. Consider a nurse helping a client with the bathing ritual; this moment can not only be used to perform this specific care task, but also to connect with the resident by discussing the day.

Current literature has stressed the importance of nursing home residents’ family members.<sup>26,27</sup> This is underscored by our findings: relationships in a nursing home exist on several levels including those between residents, their families and nursing staff. A balance exists between these



stakeholders in valuing the visits of family members. However, a disbalance exists when family reported to feel ‘obligated’ to visit. Research has shown that family experience several barriers to visit residents, including psychological factors, health issues and relationships with nursing staff.<sup>28</sup> However, family involvement is known to contribute to the well-being and perceived quality of life of their loved ones.<sup>29,30</sup> In addition, by being more involved, family-nursing staff communication can improve, allowing for enhanced engagement and more knowledge-transfer regarding important information about the resident’s preferences.<sup>31</sup>

Although our results underscore the shared value of autonomy,<sup>32</sup> they also suggest that autonomy is often limited because of time constraints. While all stakeholders mention to value residents’ autonomy, nursing staff do mention that feelings of hurriedness create a disbalance. In order to get all their work done, and to not let other residents wait, they report to sometimes take over tasks that residents might still be able to perform themselves. Emerging research confirms that resident autonomy is not sufficiently supported in almost half of the daily care activities.<sup>32</sup>

This exploratory study is the first to discuss value related to quality of long-term care from a Balanced Centrality perspective thereby providing a foundation for research on our understanding of interrelationships of various stakeholders. In order to accomplish trustworthiness within this qualitative study, the credibility of the current study was increased by triangulation of sources (i.e., participants from various long-term care organizations) and analyst triangulation (i.e., two researchers independently conducted the open coding process, three researchers conducted the axial coding process, and the interpretation of the results were discussed by all researchers). However, some methodological considerations should still be discussed. First, this study is limited in its stakeholders: only residents, their family and nursing staff were interviewed. Future research could elaborate by inviting more stakeholders. In addition, this study included twelve interviews. It could be suggested that by including more interviews, a more diverse set of values are made explicit. However, interviews that were included were chosen to be diverse in their sentiment and agreement towards quality of care. Lastly, it might be argued that the focus of the interviews (i.e., quality of care from the residents’ perspective), might have influenced the responses regarding the values of family members and care professionals. However, as apparent from the results, all three groups were eager to discuss their ideas, values and feelings over a large variety of topics related to quality of care.

### Implications for daily practice and future research

Our results confirm that experiences occur during the interactions between residents, family and nursing staff.<sup>4</sup> The importance of ‘relationship-centered care’ is highlighted, which emphasizes a balance between the needs and values of these stakeholders to achieve quality. Long-term care organizations can advocate a supportive view on Balanced Centrality by including residents, family and nursing staff in discussing quality of care and embedding these conversations into daily practice.<sup>12</sup> Focus can be placed on reciprocity, working together and sharing possibilities.<sup>33</sup> Frequently collecting information on these stakeholders’ interests, values and needs, can result in improved quality of care, life and work. The theoretical principle of Balanced Centrality, i.e., creating balance between values and needs of various stakeholders, might also be transferable to other settings and countries.

Further research is required to understand how to facilitate Balanced Centrality in long-term care, where currently ‘person-centeredness’ mostly prevails. This includes questions such as ‘How can care organizations support their staff in seeking Balanced Centrality?’ and ‘How can we assure family experiences genuine partnership as informal caregiver?’ In addition, insights into what this change of perspective means for nursing staff is warranted: how does this approach change their daily care provision? Future research could also consider other stakeholders, including volunteers, since their involvement in nursing homes is ever expanding.

### Conclusion

This study introduced a Balanced Centrality approach in long-term care for older adults, supporting the delicate balance between residents, family and nursing staffs’ needs. It underscores that, although several values and needs are aligned between these three groups, other values regarding experienced quality of care display discordance. Especially in a setting as complex as nursing homes, where the most vulnerable people in society reside, it is important that a more Balanced Centrality approach is adopted. Only when a balance between residents, family and nursing staffs’ values and needs is achieved, the well-being of all stakeholders can be improved.

### Declarations

#### *Ethics approval and consent to participate*

After a participant gave written informed consent, the interview was audio-recorded. The study was carried out in accordance with all relevant (ethical) guidelines and regulations. The study was approved by Maastricht University. Ethical approval was provided by Zuyderland Ethics Committee (17-N-86 METC Zuyderland).

### **Consent for publication**

NA.

### **Availability of data and materials**

The dataset generated and analysed during the current study are not publicly available due to ethical reasons (i.e. the verbatim transcribed text often includes personal data and information such as names and locations), but are available from the corresponding author on reasonable request (if de-identification is possible).

### **Competing interests**

None to declare.

### **Funding**

NA.

### **Authors' contributions**

SA wrote the manuscript and lead the concept, design and analyses of the study. EdV and KS contributed to the analyses of the manuscript. GO and HV contributed to data interpretation and revision of the manuscript.

### **Acknowledgements**

The authors would like to thank all the participants. Without their time investment, this project would not have been possible.

### **References**

1. (2007) WHO. *People-Centered Health Care*. 2007. [http://www.wpro.who.int/health\\_services/people\\_at\\_the\\_centre\\_of\\_care/documents/ENG-PCIPolicyFramework.pdf](http://www.wpro.who.int/health_services/people_at_the_centre_of_care/documents/ENG-PCIPolicyFramework.pdf).
2. Vaismoradi M, Wang IL, Turunen H, Bondas T. Older people's experiences of care in nursing homes: a meta-synthesis. *International nursing review*. Mar 2016;63(1):111-21. doi:10.1111/inr.12232
3. Black HG, Gallan AS. Transformative service networks: cocreated value as well-being. *Serv Ind J*. 2015;35(15-16)
4. Sion KYJ, Verbeek H, de Boer B, et al. How to assess experienced quality of care in nursing homes from the client's perspective: results of a qualitative study. *BMC Geriatr*. Feb 17 2020;20(1):67. doi:10.1186/s12877-020-1466-7
5. Roen I, Kirkevold O, Testad I, Selbaek G, Engedal K, Bergh S. Person-centered care in Norwegian nursing homes and its relation to organizational factors and staff characteristics: a cross-sectional survey. *Int Psychogeriatr*. Sep 2018;30(9):1279-1290. doi:10.1017/S1041610217002708
6. Stolk-Vos AC, van de Klundert JJ, Maijers N, Zijlmans BLM, Busschbach JJV. Multi-stakeholder perspectives in defining health-services quality in cataract care. *Int J Qual Health Care*. Aug 1 2017;29(4):470-476. doi:10.1093/intqhc/mzx048
7. Pinho N, Beirao G, Patrício L, Fisk RO. Understanding value co-creation in complex services with many actors. *Journal of Service Management*. 2014;25(4):470-493.
8. Abbate S. Reframing Holistic Patient Care in Nursing Homes Through the Lens of Relational Autonomy. *Holist Nurs Pract*. Jan-Feb 01 2021;35(1):3-9. doi:10.1097/HNP.0000000000000419
9. Gummesson E. Extending the service-dominant logic: from customer centricity to balanced centricity. *J Acad Mark Sci*. 2007;36(15-17)
10. Plé I, Cáceres RC. Not always co-creation: introducing interactional co-destruction of value in Service-Dominant Logic. *Journal of Services Marketing*. 2010;24(6):430-437.
11. Danaher TS, Gallan AS. Service Research in Health Care: Positively Impacting Lives. *J Serv Res*. 2016;
12. Sion KYJ, Verbeek H, Zwakhalen SMG, Odekerken-Schroder G, Schols J, Hamers JPH. Themes related to experienced quality of care in nursing homes from the resident's perspective: a systematic literature review and thematic synthesis. *Gerontol Geriatr Med*. Jan-Dec 2020;6doi:10.1177/2333721420931964
13. Robertson S, Cooper C, Hoe J, Lord K, Rapaport P, Livingston G. Why do staff and family think differently about quality of life in dementia? A qualitative study exploring perspectives in care homes. *Int J Geriatr Psychiatry*. Dec 2019;34(12):1784-1791. doi:10.1002/gps.5193
14. White EM, Aiken LH, Sloane DM, McHugh MD. Nursing home work environment, care quality, registered nurse burnout and job dissatisfaction. *Geriatr Nurs*. Mar - Apr 2020;41(2):158-164. doi:10.1016/j.gerinurse.2019.08.007
15. Mc Coll-Kennedy JR, Snyder H, Elg MH, et al. The changing role of the health care customer: review, synthesis and research agenda. *J Serv Manag*. 2017;28(1):2-33.
16. Sion K, Verbeek H, de Vries E, et al. The Feasibility of Connecting Conversations: A Narrative Method to Assess Experienced Quality of Care in Nursing Homes from the Resident's Perspective. *International journal of environmental research and public health*. Jul 15 2020;17(14)doi:10.3390/ijerph17145118
17. Verbeek H, Zwakhalen SMG, Schols JMGA, Kempen GJJM, Hamers JPH. The living lab in ageing and long-term care: a sustainable model for translational research improving quality of life, quality of care and quality of work. *J Nutr Health Aging*. 2019;(24):43-47. doi:https://doi.org/10.1007/s12603-019-1288-5
18. Sion KYJ, Haex R, Verbeek H, et al. Experienced Quality of Post-Acute and Long-Term Care From the Care Recipient's Perspective-A Conceptual Framework. *J Am Med Dir Assoc*. Nov 2019;20(11):1386-1390 e1. doi:10.1016/j.jamda.2019.03.028

19. Sion K, Verbeek H, Aarts S, et al. The Validity of Connecting Conversations: A Narrative Method to Assess Experienced Quality of Care in Nursing Homes from the Resident's Perspective. *International journal of environmental research and public health*. Jul 15 2020;17(14)doi:10.3390/ijerph17145100
20. Sion KYJ, Rutten JER, Hamers JPH, et al. Listen, look, link and learn: a stepwise approach to use narrative quality data within resident-family-nursing staff triads in nursing homes for quality improvements. *BMJ Open Qual*. Sep 2021;10(3)doi:10.1136/bmjopen-2021-001434
21. Glaser BG, Strauss AL. *The Discovery of Grounded Theory: Strategies for Qualitative Research*. 1967.
22. Marzorati C, Pravettoni G. Value as the key concept in the health care system: how it has influenced medical practice and clinical decision-making processes. *J Multidiscip Healthc*. 2017;10:101-106. doi:10.2147/JMDH.S122383
23. Braun V, Clarke V. Using thematic analysis in psychology. *Qualitative Research in Psychology*. 2006;3(2):77-101.
24. Slettebo A, Kirkevold M, Andersen B, et al. Clinical prioritizations and contextual constraints in nursing homes--a qualitative study. *Scand J Caring Sci*. Sep 2010;24(3):533-40. doi:10.1111/j.1471-6712.2009.00745.x
25. Chan EA, Jones A, Fung S, Wu SC. Nurses' perception of time availability in patient communication in Hong Kong. *J Clin Nurs*. Apr 2012;21(7-8):1168-77. doi:10.1111/j.1365-2702.2011.03841.x
26. McCormack B. Person-centredness in gerontological nursing: an overview of the literature. *J Clin Nurs*. Mar 2004;13(3a):31-8. doi:10.1111/j.1365-2702.2004.00924.x
27. Hoek LJ, van Haastregt JC, de Vries E, Backhaus R, Hamers JP, Verbeek H. Partnerships in nursing homes: How do family caregivers of residents with dementia perceive collaboration with staff? *Dementia (London)*. Jul 2021;20(5):1631-1648. doi:10.1177/1471301220962235
28. Miller VJ. Investigating Barriers to Family Visitation of Nursing Home Residents: A Systematic Review. *J Gerontol Soc Work*. Apr 2019;62(3):261-278. doi:10.1080/01634372.2018.1544957
29. Gaugler JE. Family involvement in residential long-term care: a synthesis and critical review. *Aging Ment Health*. Mar 2005;9(2):105-18. doi:10.1080/13607860412331310245
30. de Jongh A, Erdmann S. Better healthcare must mean better for patients and carers. *BMJ*. May 17 2018;361:k1877. doi:10.1136/bmj.k1877
31. Groven F, Odekerken-Schroder G, Zwakhalen S, Hamers J. Network well-being from a balanced centrality perspective. *Journal of Services Marketing*. 2021;35(9):1-14.
32. Hoek LJM, Verbeek H, de Vries E, van Haastregt JCM, Backhaus R, Hamers JPH. Autonomy Support of Nursing Home Residents With Dementia in Staff-Resident Interactions: Observations of Care. *J Am Med Dir Assoc*. Nov 2020;21(11):1600-1608 e2. doi:10.1016/j.jamda.2020.04.013
33. Puurveen G, Baumbusch J, Gandhi P. From Family Involvement to Family Inclusion in Nursing Home Settings: A Critical Interpretive Synthesis. *J Fam Nurs*. Feb 2018;24(1):60-85. doi:10.1177/1074840718754314