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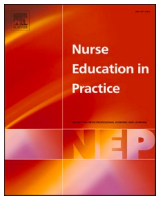

Learning as a way of achieving quality improvement in long-term care: A qualitative evaluation of The Story as a Quality Instrument

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ABSTRACT

Aim/Objective: This study aimed to evaluate the use of the narrative quality instrument 'The Story as a Quality Instrument' (or SQI) for learning as a way of achieving quality improvement.
Background: Learning is a widespread aim in long-term care. If professionals share detailed information about their views on the quality of care, they can see it from each other's perspective and create a new joint perspective that may generate a broader meaning in total. One useful source for learning and improvement is the narratives of older adults. These narratives enable reflection and learning, which encourages action. In care organizations, there is a drive to find methods that can be used to facilitate learning and encourage quality improvement.
Design: A qualitative evaluation design.
Methods: Data collection was performed in 2021–2022 at six field sites of four large care organizations providing long-term care to older adults in the Netherlands. At each field site, SQI was applied: an action plan was formulated in a quality meeting and, 8–12 weeks later, the progress was evaluated in a follow-up meeting. The data collected was participants' responses during focus groups: the verbatim transcripts of both meetings and the observation reports of the researchers. 46 participants took part in the quality meetings and 34 participants were present at the follow-up meetings. The data was analyzed using thematic analysis.
Results: The results are mechanisms that help learning, participant responses, and practical challenges and conditions. Four mechanisms became visible that encourage learning among participants for achieving quality improvements: in-depth discussions, exchange of perspectives, abstraction, and concretization. The participants listed several outcomes regarding individual learning such as change of attitude, viewing older adults more holistically and the realization that possibilities for working on quality improvement could be just a small and part of everyday work. Participants learned from each other as they came to understand each other's perspectives. The added value lay in getting insights into the individual perceptions of clients, the concrete areas for improvement as an outcome, and getting a picture of the perspectives of diverse people and functions represented. Time was found to be the main challenge when applying SQI.
Conclusions: SQI is deemed promising for practice, as it allows care professionals to learn in their workplace in a structured way from narratives of older adults in order to improve the quality of care.

1. Introduction

Trends in western societies have increased the focus on person-centered care to take account of the individual values, needs and preferences of older adults receiving care and support (McCormack and McCance, 2016). Person-centred care has been identified as a fundamental component of healthcare quality, as the experiences of clients and care professionals with care provision and the relational aspect of care are emphasized (Santana et al., 2020). To measure the quality of care adequately from a client perspective, qualitative methods are increasingly being used to map out their diverse life experiences from everyday practice (Ubels, 2015; Sion, 2021). Dominant accountability has been operationalized mostly quantitatively and for external purposes, but often failed to focus on what care professionals really need to foster learning, encourage reflection and work towards quality improvement (Raad voor Volksgezondheid en Samenleving RVS, 2019; Reinders and Nazarowa, 2020). Policymakers and care organizations are increasingly underlining the importance of organizing quality research

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within the care process system in specific contexts (Ubels, 2015; Van Loon and Zuiderent-Jerak, 2012). Care professionals and clients should have a voice in quality improvement, as they offer important insights into the care process and decide on their needs and priorities (Balbale et al., 2016; Bergerum et al., 2019; Molapo et al., 2016). Involving members with different backgrounds and expertise lays the various perspectives bare and brings them together (Trischler et al., 2019).

One useful source for learning and improvement is the narratives of clients. Narratives make reflection and learning possible by triggering tacit knowledge and encouraging action (Bartel and Garud, 2009; Garud et al., 2011). Posing one or at most just a few questions means that a question-and-answer structure can be avoided in narrative research to let the client tell and interpret their own experiences on their own terms (Hsu and McCormack, 2012). Narratives can be used to explore what clients value in care, based on their personal experiences of their situations, in which the focus is not only on the illness but rather on the person as a whole (Haydon et al., 2018). Care professionals can get a more in-depth understanding of the clients' point of view in which nuances and layers of information are covered (Wang and Geale, 2015). It provides unique insights into how someone interprets the world (Riley and Hawe, 2005). Reading a narrative allows a reconnection to be made with an experience of a specific client in a specific context and place (Hsu and McCormack, 2012).

Professional reflection and learning are a widespread aim in care. However, the frictions, disagreements and contradictions at a deeper level are not always discussed and unraveled, while this is essential for finding possibilities for quality improvement (Reinders and Nazarowa, 2020). Learning at the workplace is seen as both an individual and a social collective process in which knowledge is co-constructed by explaining and reflecting on experiences and assumptions together. In these interactions, understandings are developed and tacit knowledge is transformed into explicit knowledge (Snoeren et al., 2015; Billett, 2006; Muller-Schoof et al., 2022). Reflection is seen as a core process for making experiences meaningful and being able to criticize, test and revisit knowledge derived from spontaneously gained experiences in intensive interaction among professionals (Snoeren et al., 2015). When professionals share detailed information about events and their perspectives, they can cross into each other's domains, give advice, and create a new perspective that may generate a broader meaning than could have been accomplished by individuals (Bartel and Garud, 2009; Nonaka, 1994).

Engaging in dialogs can trigger learning at the workplace by transforming individuals, a team and even organizational practices (Manley et al., 2009). Cooperating and interacting with colleagues and reflecting on your own work experiences are two forms of work-based learning (Tynjälä, 2008). Reflective spaces – also called safe spaces or comfort zones – are hereby key in learning processes, as tacit and explicit knowledge are both bridged when people come together to reflect on challenges and needs in daily work practice using concrete practices (van de Bovenkamp et al., 2020; Wiig et al., 2021). A key task for organizations is to facilitate collective learning (Bartel and Garud, 2009).

As care organizations are responsible for facilitating learning and encouraging quality improvement (Raad voor Volksgezondheid en Samenleving RVS, 2019; Zorginstituut, 2017), there is an urge to find methods and instruments that can be used for this goal. The narrative quality instrument called 'The Story as a Quality Instrument' was developed in the Netherlands to encourage learning as a way of achieving quality improvement. Care professionals interview older adults with whom they do not have a care relationship, in a narrative process involving one simple open invitation and thereafter following the flow of a natural conversation. Care professionals use the transcript of the interview afterwards to draft a holistic portrait of the narrative of the older adult. In a quality meeting, the holistic portraits are used by stakeholders to learn and reflect on the content of the narratives of older adults. They formulate concrete areas for improvement together letting them work towards quality improvement (Scheffelaar et al., 2021;van Delft et al., 2023). The procedure for quality improvement was recently developed in co-creation with stakeholders to provide a systematic method for encouraging learning and quality improvement. Before the procedure is offered to and used by care organizations in the Netherlands, it is important to substantiate and evaluate the procedure. The aim of this study is therefore to evaluate the procedure we developed as a means for learning to realize quality improvements in long-term care for older adults.

2. Method

2.1. Study design

This study concerns a qualitative evaluation of the newly developed procedure of 'The Story as a Quality Instrument' for learning as a way of achieving quality improvement. That procedure is referred to hereinafter as SQI. The procedure developed is the second phase of SQI: the quality improvement procedure comprising a quality meeting and a follow-up meeting (see Fig. 1 and Table 1). The evaluation took place between June 2021 and July 2022 on six field sites of four large care organizations providing long-term care to older adults in the Netherlands. Fig. 2.

2.2. Setting

In our Academic Collaborative Center (ACC) for Older Adults of Tilburg University, researchers collaborate with eleven organizations (of which ten provide care for older adults) to create both scientific knowledge and social impact in order to improve the quality of person-centered care for older adults (Luijkx et al., 2020). In the current study, six locations of four long-term care organizations collaborated. Five of the locations provide residential care in nursing homes, while one location offers home care to older adults living independently. At every location, a diverse group of older adults, care aides, nurses, social workers, quality employees and management participated in the study.

2.3. Data collection

The data collection comprised three sources. The first source of data was the observations of the researchers present at all quality meetings and follow-up meetings (AS, MJ, EvD). A list of sensitizing concepts was used for the observations, defined beforehand. From each meeting, the researcher made quick notes on the impressions during the meeting and wrote a report of 1–3 pages. The second source concerned the quality meetings and follow-up meetings: these were audio-recorded and transcribed verbatim and all additional materials (action plans, posters, Post-Its) were collected afterwards. The third source of data concerned the experiences of participants with SQI shared during a focus group at the end of the quality meeting and the follow-up meeting. The focus group at the end of the quality meeting took between 10 and 15 min, and 20–30 min were scheduled after the follow-up meeting. These focus groups were audio-recorded and transcribed verbatim.

2.4. Data analysis

The data was analyzed by two researchers (AS, MJ) independently using qualitative thematic analysis. Thematic analysis is known as an accessible and flexible method of qualitative data analysis which simultaneously provides a systematic procedure for analysis. The analysis style used can be positioned as a primarily inductive and experiential orientation to the data (Braun and Victoria, 2012). The qualitative data analysis program Atlas.ti 22 was used to analyse, structure and restore the analysed data. First, all data collected at one pilot location was analysed by the two researchers independently and the first topics were then discussed by the researchers (AS, MJ). An initial list of themes was set up as a first draft of a coding tree. After that, the researchers

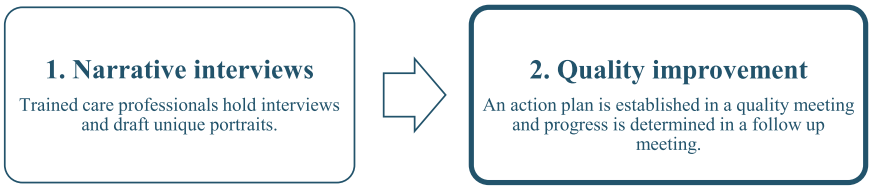

Fig. 1. Visual presentation of the two phases of SQI.

Table 1
Description of the procedure for quality improvement.

The Story as a Quality Instrument (SQI) consists of 1) a procedure for collecting narratives and 2) a procedure for quality improvement (see Fig. 1).

1. Narrative interviews

After training, 3–4 care professionals (i.e. care aides, nurses, quality nurses, quality employees, social workers) at every field site interviewed older adults with whom they did not have a care relationship. To allow the older adult to talk about their experiences freely, the interview starts with a simple open invitation: "*You have been receiving care at Organization X for a while. Please tell me about this*." The interviewer is instructed to not introduce any further themes but to keep the conversation going so that it follows the flow of a natural conversation. When the older adult seems to have finished their story, the interview moves into the second stage. In the second part of the interview, probing questions are posed to gain supplementary information. Interviews are audio-recorded and transcribed verbatim afterwards and used by the care professional to create a holistic portrait of each interviewed older adult. A detailed description has been published elsewhere (Scheffelaar et al., 2021; van Delft et al., 2023).

2. Quality improvement

SQI aims to work on quality improvement by translating the content of the portraits into concrete areas for improvement at the team or location level, thereby working towards person-centered care. The quality improvement procedure consists of a quality meeting and a follow-up meeting that were developed in co-creation with stakeholders to realize a good fit with the needs, conditions and priorities of care practice. A maximum of 8 participants are invited in addition to the moderator, comprising employees who provide care – care aide, nurse, social worker - and those with more policy-oriented functions such as a policy advisor, quality advisor, team manager or quality nurse. Additionally, a client representative is invited. A moderator is responsible for facilitating the meeting, while a process lead is responsible for the whole execution of the process, including the organization of the meetings.

- *Quality meeting*
  As preparation, all participants are asked to read 3 portraits in advance of the quality meeting and identify compliments and areas for improvement of care. At the start of the meeting, the moderator explains the aim of the meeting, the program and the basic agreements (anonymity, don't blame individuals, open attitude towards learning). Thereafter, small groups discuss the selection of portraits they read in advance of the quality meeting and the areas for improvement and successes they derived from the portraits. During the discussion, they write down the points for improvement and successes on Post-Its. All Post-ts are shared in the whole group and thematically clustered. For each theme, the group reflects on what the real problem is, in order to address the issue instead of a superficial result. The participants prioritize the themes by choosing 3 they find most important. The 3 prioritized themes are then used to develop an action plan. Concrete points for improvement are formulated. Moreover, clear and SMART agreements are made for every theme: who is going to work on this and how. For every theme, one person is made responsible. After the meeting, a short report including the action plan is set up. This report is shared with clients to ask whether they can approve the plan. After their approval, subgroups of employees work on the actions meant to improve the quality of care.
- *Follow up meeting*
  After 8–12 weeks, a follow-up meeting takes place in which the participants evaluate the actions carried out, discuss the successes achieved, and decide whether follow-up steps are necessary.

analysed three different locations (MJ 1 location and AS 2 locations), refined the coding tree and discussed the findings in detail. The first researcher (AS) analysed the data of the last two locations with the coding tree as developed. As is common in thematic analysis, the qualitative data was analysed using a cross-case synthesis. By focusing on meaning across the data set, the researchers made sense of the shared meanings and experiences of participants. The researchers did not focus on unique meanings found only within a single data item (Braun and Victoria, 2012). Dilemmas and questions arising during data collection and analysis were discussed in peer debriefings by all three authors. The researchers involved all obtained their Ph.D., have substantial experience with qualitative research with a background in social sciences.

2.5. Ethical considerations

The study was approved by the Ethics Review Board (ERB) of the School of Social and Behavioral Sciences of Tilburg University (reference RP331). Participants received both written and verbal information about the study. Those who decided to participate gave their consent by signing an informed consent form.

3. Results

The results are divided into four main paragraphs. After a short description of the participants, the four mechanisms for action and learning that came to the fore during analysis are described. This section is followed by the participants' responses to the outcomes regarding individual learning, collective learning and the added value of SQI. Lastly, the practical challenges and conditions for the future are reported. The coding tree is included in Annex 2.

3.1. Participants

A sum of 46 participants took part in the six quality meetings spread over the six locations, and 34 were present at one of the six follow-up meetings. Seven to nine participants contributed to the quality meeting (M = 7.7) and four to eight participants were present at the follow-up meeting (M = 5.6). A nurse and manager were always present in the quality meeting, while a care aide, client representative and quality employee were represented at almost all (5 out of 6) locations. Other functions such as social work, nutritionist, intern and psychologist were sometimes represented (see Annex 1 for details). These participants also took part in the evaluation of SQI. The follow-up meetings were rescheduled at 3 locations due to coronavirus outbreaks and staff shortages.

3.2. Mechanisms for learning

In the quality meetings, four mechanisms became visible that encouraged learning among participants to achieve quality improvements together: in-depth discussion, exchange of perspectives, abstraction, and concretization. These mechanisms are described below using specific, detailed examples from the data.

- ***In-depth discussion of needs and possibilities***

In the quality meetings, the content of the portraits and the central themes were discussed in-depth. Participants tried to interpret and track down the underlying needs and motivations of clients that became visible in the portraits. For instance, the participants at one quality meeting tracked down the underlying reason why a specific activity was proposed by a resident and perceived as important for his wellbeing.

> *"Underlying this, a need is expressed there saying that it's nice to have a meaningful... a useful day and to do something meaningful."*

Fig. 2. Data used for analysis.

In another example, participants immersed themselves in the unintentional consequence of time pressure shown by care professionals, as clients shared they did not dare to ask for extra help when care aides were too busy.

"[.] the clients start taking themselves out of the equation to help our workload. And I think that's an underlying issue."

These joint reflections during the quality meetings were deemed likely to contribute to individual and collective learning.

The content of the portraits was discussed critically and extensively in the light of possibilities, responsibilities and function descriptions as well as limitations of care provision. In one quality meeting, the manager encouraged the group to think outside the current policy and try to think creatively about opportunities.

"*You've always got more influence than you think. That's really true: if you think about something, you can always find a handle that lets you get just a little bit more along your way, and I reckon we can do that here.*"

In other instances, the limitations of care provision became visible. In one discussion, the participants concluded that the personal wishes of clients regarding the daily lunchtime meal could not always be taken into account, as it was sometimes too diverse or expensive to offer. Instead of granting all lunch wishes, the participants of this meeting concluded that it was more important to communicate the food list to make explicit what choices were (and were not) available.

- ***Exchange of perspectives***

At the quality meetings, a variety of functions were represented: nurse aides, nurses, quality employees, client representatives, managers and social workers (see Annex 1). These participants brought in the perspectives of their various disciplines. First, the participants tried to relate to the perspectives of the clients who shared their experiences based on the portraits they read.

"*So I try to turn it round a bit, like, how'd you feel then?"*

In some instances, the 'truth' of the perspective of a client in the portrait was contested.

"*We had quite a few doubts, like. the tale doesn't always click, what you're told doesn't always match the reality."*

In this specific meeting, an extensive discussion arose about different perceptions and someone argued that all perceptions have additional value in themselves, although sometimes, these might not be consistent with each other. The moderators took care to ensure that all participants had an equal share in the discussion. Persons who were more silent were invited by the moderator to share their thoughts and ideas.

Furthermore, the diverse multidisciplinary perspectives of the participants of the quality meeting were shared. A care professional shared from her own perspective in a discussion on the continuity of staff:

"*This can also have a negative effect, because if you work for thirty-two hours, say, and you always have the same residents and you always have. then I take a look at [name of ward] where the difficult residents are, and after three days you're simply drained and then you think you'd actually like some different residents for once.*"

In another instance, a client was disappointed she was not allowed to take her beautiful carpet when she moved to the nursing home for safety reasons as it was expected to increase the risk of falls. In the quality meeting discussion, the autonomy of the client was weighed against the safety issues of fall risks that were emphasized by a care professional who was present:

"I sometimes find it difficult as a professional because they can't see the dangers."

Client representatives also brought in their own perspectives to add to the discussion:

"*It's real nice – I'm going to talk about myself just for a moment now – it's real nice when you come here as a client that you know who your contact is, that they make contact with you and that you always know you can ask further questions through them.*"

The diverse composition of the meetings was therefore likely to encourage learning from different perspectives.

Participants also discussed whether improvement areas revealed by the portraits were consistent with or conflicting with the organizational vision and policy. Sometimes an area for improvement brought forward by a client was not feasible due to organizational choices. "*A client's expectations* versus *our vision: there's some, well, there's healthy friction there, let's put it like that. [.] For the organizational perspective*."

- ***From concrete towards abstract***

In the quality meeting, participants worked from merely individual wishes towards finding areas for improvement that would be meaningful for more clients. The level of abstraction thus increased. One illustrative example is a discussion about the umbrella theme of autonomy under which three specific cases were classified. One case concerned an older adult who wanted to walk outside in his moccasin slippers where a care professional expressed concerns about the danger of falling, another case was a lady who was not allowed to bring her beautiful carpet to her new home, and the third concerned a resident who wanted his warm

meal served in the evening instead of at lunchtime. These cases from the portraits were used to discuss the larger theme of autonomy on which areas for improvement were formulated.

> "*We're now onto a discussion about a rug. how far, which is bigger, how can we make sure people have more self-direction. and so, they are at risk. Do we want to make sure they aren't at risk, or do we want them to have more self-direction?*"

For some participants, this abstraction process was observed to be a bit difficult as they had to take a step back from the concrete examples to discuss the theme more generally. Sometimes it helped when the moderator tried to break this process down into smaller steps or when other participants gave examples of directions to think in.

In some meetings, participants explicitly related one of the prioritized themes with other developments within the organization. This was sometimes helpful to the discussion, as the findings were then framed in the larger picture of relevant organizational developments. It could however also have a problematic effect if the concrete actions for improvement were not related to the input of clients anymore and became focused on the organizational developments that were already taking place. It could hamper the learning and creativity of the participants if they did not feel encouraged to think critically and come up with innovative solutions, and instead took the usual procedures for granted.

- ***From abstract to specific actions***

In the last phase of the quality meeting, concrete actions for quality improvement were formulated that would be carried out by specific people and planned in a specific period. The challenge was to find the right balance between choosing relatively small and specific actions that were feasible in the upcoming weeks and finding actions that would lead to changes towards what clients wanted regarding the quality of care. Participants sometimes found it difficult to decide which action would create noticeable change for clients. This search process in the meeting could therefore take some time.

> "*I'm searching a little for ways of carrying out the improvement actions. you want them to be fairly definite, [.] How big are we going to make it? I'm also still finding my way a bit in that sense."*

As a minimum, the actions had to transcend individual wishes brought forward by any specific client. In the meetings, the moderators helped the group to formulate concrete actions.

Participants tried to balance on the tightrope of finding actions that lay in their own sphere of influence as well as being directly helpful for multiple clients, thereby transcending the individual level.

> "*I noticed myself that I sometimes find it difficult to make ideas concrete. Because we all write stuff on those Post-its, and then you have to progress towards the action plan, as well as getting that expressed intelligently in clear steps. Yes, that's really challenging.*"

To ensure that the actions would be feasible, one process lead advised the participants to choose themes that could be improved by the people present in the meeting. In another meeting, the moderator observed afterwards that the prioritized themes were not directly related to the care provision process at the level of care professionals, while relatively many Post-Its were focused at that level. She thought that the care professionals perhaps found it difficult to choose themes that were relevant for their own work.

3.3. Outcomes

The participants reported several outcomes of SQI, either for individual learning or for collective learning.

3.3.1. Individual learning

A substantial number of participants believed SQI assisted their individual learning. SQI changed their attitude towards clients and the way they dealt with certain situations during care provision.

> "*I really started looking at people very differently and then again at the little personal questions, and once again thinking about how important it is for me. So it's influenced me, yes it* has *influenced me.*"

Others viewed older adults more holistically due to the wealth of detail in the portraits they read and took a more in-depth and personal approach towards older adults. Care professionals realized that aspects of daily life such as mealtimes could seem really minor or small for them but could make the day for a client.

> "*Then you don't really pause to think about how someone can enjoy something very small so much.*"

A client representative in the client council realized that quality of care could be approached at a much finer level of detail than policy documents:

> "*Not stopping to think about the awareness, which was actually in here, like: you can also think differently, put yourself in the shoes of the client, the person, the resident. A shift in the mindset, and so I'm trying to do that now. yet all the policies that come along, which is what we're talking about, make it a bit smaller and a bit more personal.*"

3.3.2. Collective learning

SQI also encouraged collective learning. One participant observed when she coincidentally visited another location where SQI was being applied that the care professionals genuinely questioned the policies, client behavior and their own automatic behavior at a deeper level. Participants believed that they also learned from each other, as many disciplines were present that contributed equally. Specifically, care aides underlined the fact that they were happy with the appreciation for their work that was expressed by residents in the portraits and in the quality meeting. These care aides found their work to be physically exhausting and did not always feel valued at work. Another person said she believed that SQI could generate real quality improvements from a client's perspective.

> *"I think it's a different way than filling in lists. And then for example I just pick something very simple – if we picked something else, normally we'd then think: yup, 'cos they don't like the meals again – but now we looked more at what isn't good about the meals and what can we do about it ourselves. And not that it's because of the menu."*

One nurse complained at the start of the meeting that the type of information was not really different from individual intakes she did with new clients. At the end of the meeting, however, she revised her earlier comment and said she believed that the quality meeting really added value due to the higher level of reflection by the participants on finding innovative solutions.

One unexpected outcome of the quality improvement process was that the quality process was adjusted at several locations and made more cyclical to ensure that all actions from the action plan were carried out appropriately. At some locations, an extra follow-up meeting was planned with the same participants as extra motivation to encourage action and keep each other updated. At another location, the follow-up was encouraged in regular team meetings.

> "*We have action items, so now I'm thinking like we\re actually in the review now, but we still have some way to go, so I hope this does mean we're following up on action items that are still open.*"

3.4. Added value

Participants stated five reasons why SQI was worthwhile and added

value for learning and achieving quality improvement. Getting an understanding of the experiences and individual perceptions of clients was the first advantage listed by several participants. The narrative method was viewed positively as clients determined for themselves what mattered to them – freely and without being pointed towards specific topics. The fact that clients shared their views created extra motivation among care professionals to work on the areas for improvement. Most of the information shared by clients was nothing out of the ordinary: on the contrary, quite small and mundane elements of people's daily lives. These small items in particular were seen as valuable for realizing person-centered care.

"*What I reckon is most important [.] is that we start from that client – that's why we do it – and that we pick up the stories of what matters from them.*"

A second advantage was the action plan and the concrete areas of improvement that were determined together. The specific areas for improvement made sure people did not just talk about the portraits but genuinely translated the findings into feasible actions.

"*I did very much like the way actions came out practical and how concretely it was actually sorted out afterwards.*"

A third advantage listed by participants was the educational value of the meetings. "*I'd written down that I actually find these two meetings very valuable, for both us and the clients. We learn a lot from them and that also means we can mean more for our clients."*

The structure of the meeting and the preparation assignment helped, according to the participants. A fourth advantage mentioned was the diversity of the people and various functions represented in the process.

"*Because of the diverse group of people involved, I think the solutions are feasible and that people are motivated to work on them as well.*"

Lastly, participants valued the fact that compliments and positive evaluations were shared as well as suggestions for improvements.

"It gets you more enthusiastic if you're thinking 'Yup, we're doing good things this way'. That helps confirm it, I guess."

3.5. Challenge: Time

The main challenge concerned the time invested in applying the method. Especially for the care professionals involved as interviewers, time investment was found to be a main challenge. One interview cost an average of one hour, composing the portrait cost an average of 3 h, and they attended the 3-day training course and scheduled the interviews with residents. It was sometimes difficult for care aides in particular to combine these activities with their regular work schedule. The participants in the quality meeting scheduled time for the quality meeting (2½ h), the follow-up meeting (1 ½ h), reading 3 portraits in advance individually (1 h), and following up the actions (variable).

"*I think it takes a lot of time, the whole approach. Look, I don't think the meeting itself is particularly what's intensive in terms of time; you simply need that. But if you look at the whole thing, from start to finish, the people are putting in a pretty serious chunk of time. And then I sometimes wonder how tenable is that in the future too, actually, as I really do think that story is valuable. And we're noticing that now. seeing what is coming.*"

So the method did cost time for all those involved, and participants thought differently about the question of whether the benefits outweighed the costs. At one location where the areas for improvement and compliments were less evident, a manager believed the time invested outweighed the benefits. At another location, it was also proposed to let students become involved as interviewers during their internships to reduce the workload for employees.

3.6. Conditions

- ***Underlining the importance of anonymity***

All portraits were anonymized before they were used in the quality meeting. Moreover, participants were asked to formulate actions for improvement at a higher level than the individual client, even though they knew which clients had mentioned specific wishes. Some participants observed that the combination of specific information could also be traced back to individuals despite the portraits being anonymized. They therefore underlined the importance of the basic agreement only to use the information read in the quality meeting for improvement purposes and refrain from gossiping afterwards or speaking to a client about a statement they might have made during an interview.

- ***Quality of the portraits in terms of usefulness***

In a few instances, participants were hesitant to interpret the portraits and translate them into an action plan as they felt that one or more portraits lacked detail and information. When too many aspects were left open in a portrait, participants had to interpret the gaps themselves, leaving them unsure whether their interpretation was in line with the interviewed client.

"*We noticed in some cases that we didn't have enough information to really tell what we could we start doing as an improvement action."*

This also related to the degree of openness of the client: whether they felt free to tell all nuances and details of their experiences or only gave short answers.

- ***Embedding structurally***

Participants suggested several opportunities where SQI could be embedded structurally in a care organization. First, it was deemed to be important that SQI should be accepted at the policy level by making a connection with the organizational vision to explain the logic for implementation and to create support among the staff. Management could have a facilitating role here.

Participant A: "*From management side too, of course – how it is expressed to the teams, as it were."*

Participant B: *"Facilitating."*

Participant A*: "The organization should just approach it positively; that atmosphere changes right away then.*"

The added value and relationship with other quality initiatives within any given care organization should also be clearly defined.

More practically, the time needed for the data collection (interviewing, drafting portraits) should be planned in advance in the work schedules of the interviewers. Focusing on one project instead of working on multiple projects simultaneously was suggested as possibly being helpful, as was making a realistic timeline. Furthermore, the action plan could be embedded in regular meetings, by coming back to the progress briefly multiple times. It is therefore important to schedule enough time though, as was observed in one follow-up meeting that was integrated into a regular meeting (thus reducing the time available for discussing the status of the action plan). The roles should be assigned clearly to specific people and functions in the organization.

- ***Communication***

One question for future implementation is how to communicate the action plan and findings to employees, clients and relatives who were not present during the quality meeting and follow-up meeting. For successful execution and realization of the action plan, this was deemed to be an essential step and several proposals and ideas were given for accomplishing this. Including examples from the portraits and personal briefing by participants in the quality meeting was proposed as a way of

informing people adequately. For employees, it was proposed that they should be informed regularly in team meetings. Furthermore, care teams were informed by the process leader by e-mail; in another case, a digital newsletter would be sent to employees. For clients, the regular home newsletter was proposed in which clients and relatives were informed of all news. Organizing a larger information meeting was also suggested. At one location, the action plan was also presented and shared with the client council by the client representative who was present.

4. Discussion

This study aimed to evaluate the use of 'The Story as a Quality Instrument' or SQI as a way of learning from clients' narratives in order to realize quality improvement. A new procedure was developed and evaluated with care professionals, quality employees, management and older adults. Four mechanisms became visible that encourage learning among participants to achieve quality improvements: in-depth discussion, exchange of perspectives, abstraction, and concretization. The participants reported several outcomes for individual learning, such as a change of attitude and viewing older adults more holistically. Participants learned from each other, as they gained an understanding of each other's perspectives. The added value of SQI for learning and achieving quality improvement lay in the pictures gained of the individual perceptions of clients, the educational value of the meetings, the concrete areas for improvement as an outcome, and the diversity of people and functions participating. Time was found to be the main challenge for applying SQI.

The benefits of SQI for care professionals involved as interviewers was made clear in an earlier study. Specifically, SQI elicited clients' experiences in a genuinely personal way, in which they address topics they themselves find important. Also limitations and prerequisites for interviewers were reported in this related article (van Delft et al., 2023). The current study shows that, the portraits provided insight into the mundane, small elements of people's daily lives, including when care professionals are not involved in the interviews themselves. The personal, subjective and multi-layered experiences of older adults provide an interesting point of view from someone else's perspective. Taking the worldview of older adults as a starting point for quality improvement might seem very obvious and straightforward, but is actually not often the standard in learning and quality improvement initiatives in long-term care. This study shows the educational value of the narratives of older adults for reflection and learning when aiming for person-centred care.

A recently published scoping review by Muller-Schoof et al. (2022) that focused on learning mechanisms of practically trained care professionals is relevant in the light of the findings of the current study. Individual learning, collective learning and resources for learning were conceptualized as inherently interrelated and influencing each other. Contributing factors for collective learning were sharing knowledge, reflecting on care processes together, and discussing diverse perspectives in a safe environment (Muller-Schoof et al., 2022). The learning mechanisms identified in the quality meetings in the current study ('In-depth discussion of needs and possibilities' and 'Exchange of perspectives') are very much in line with these previous findings. Moreover, resources for learning in the scoping review were structures for learning, materials and organizational support (Muller-Schoof et al., 2022). The quality improvement procedure of SQI can benefit the structure for learning and provides concrete materials for it. Finally, Muller-Schoof et al. (2022) underlined the relevance of creating a feeling of ownership among care professionals for work-based learning. In SQI, care professionals are performing a key role, as interviewers in the collection of narratives and as contributors in the quality improvement process. These roles are expected to encourage the influence of care professionals on their informal work-based learning and on quality improvement, by re-confirming their key position.

In long-term care, the concept of 'collective tinkering' was recently introduced as a way of understanding how care professionals, clients and family members are inventing and experimenting with care practices constantly to deal with tensions in values and different views on ontologies. Narrative quality instruments are proposed as a helpful way of encouraging critical reflection and development of other skills needed for collective tinkering as practiced in the procedures. A narrative quality instrument can provide a structure and space for the wider collective to shape care practices together (Heerings, 2022). Regulatory bodies and supervisory authorities in the Netherlands are also currently experimenting with forms of narrative and reflexive accountability, as a useful way of using narrative information for reflection and work-based learning (Raad voor Volksgezondheid en Samenleving RVS, 2019; Pot, 2022). This development might create space for care organizations to experiment with learning and reflection based on client narratives.

This article has several strengths. First, this study increases knowledge on the topic of learning in the workplace, something that has so far been insufficiently studied (Muller-Schoof et al., 2022). Second, quality instruments for nursing home practice are often developed without scientific substantiation or systematic evaluation. At the start of this study, little was known about how narratives can best be collected and used in practice for quality improvement (Triemstra and Francke, 2017), as using narratives for quality improvement through learning is a relatively new development. This study helps fill the current gap in the literature. Another strength is the research method, as the triangulation of data – participant observation, transcripts and participant responses – provide a comprehensive answer to the research question. SQI was used at six locations and observed and evaluated systematically by the three researchers involved.

Every study also has its limits; three limitations of the current study are given here. One potential limitation of this study is the dual role of the first author in both developing and evaluating SQI. Several mechanisms were built in the process to diminish potential biases and guarantee an open attitude during data collection and analysis. During development of the instrument, the researcher facilitated the co-creation process while stakeholders from practice developed the content of the instrument. During the pilots, employees of the care organizations were responsible for implementing the instrument. To reduce bias among care professionals due to role entanglement, different care professionals were involved in the development phase and the pilot stage. Two researchers involved in data collection and analysis were not involved in the development stage of the instrument (MJ, EvD). A second limitation concerns the characteristics of an explorative qualitative study design. With the current study design, the process of SQI was evaluated based on observations and experiences of the stakeholders involved. The actual change generated by the quality improvement procedure or the extent to which the participants actually learned and apply lessons learned in practice were outside the scope of this study. The third limitation concerned the contextual circumstances affecting the environment of this study (i.e. the coronavirus crisis). Due to coronavirus measures, all quality meetings were postponed. One follow-up meeting was planned digitally via Zoom. As regular team meetings could not always be held, the implementation of the action plans was sometimes noted to have been delayed. Moreover, a high level of sick leave among personnel and staff shortages increased the work pressure at some locations. These circumstances made the period of the study execution turbulent for participating organizations and delayed the data collection for this study.

Developing an evidence-based instrument was the first exciting step completed. A toolbox including a training for interviewers, an instruction manual for the moderator and process lead, and materials supporting the quality meeting and follow up meeting are available for future use of SQI. Successful implementation is definitely a demanding next step that requires continuing efforts – from within the care organizations, from the trainers, and from the developers. It will be insightful to evaluate the further implementation of SQI in the future to provide insight into the implementation process, conditions and impact on the

quality of care and learning. Furthermore, researchers can study the actual changes in care practices and policies related to the performance of SQI and the feasibility of the SQI outcomes more closely in the future.

5. Conclusion

The Story as a Quality Instrument (SQI) is deemed promising for practice, as it allows care professionals to learn in a structured way from narratives of older adults in order to improve the quality of care. SQI specifically aimed to translate narrative portraits with stakeholders – care professionals, quality employees, a manager and a client representative – into improvement actions targeting quality improvement at the team or location level in the long-term care of older adults. The quality meeting and follow-up meeting were feasible in general while the time investment was found to be a challenge in practice. For future implementation, communication and structural embedding of the instrument in care organizations are important conditions. In future research, it will be insightful to evaluate the further implementation of the story as a quality instrument to deepen the understanding of the implementation process and the impact on the quality of care and learning.

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CRediT authorship contribution statement

Conceptualization: AS, MJ, KL. Methodology: AS, MJ, KL. Formal analysis: AS, MJ. Validation: MJ. Investigation: AS. Project administration: AS. Data Curation: AS. Software: AS. Visualization: AS. Writing original draft: AS. Writing – review & editing: MJ, KL, AS.

Declaration of Competing Interest

None.

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Annex 1. Overview of participants in the quality meeting and follow-up meeting

Field site 1	Field site 2	Field site 3	Field site 4	Field site 5	Field site 6
Quality meeting					
Attendance n = 9 3 care aides 1 nurse 1 social worker 1 manager 1 client representative 1 quality officer 1 communication professional	Attendance n = 7 1 care aide 2 nurses 1 manager 1 client representative 2 quality officers	Attendance n = 8 2 care aides 2 nurses 1 manager 1 client representative 1 intern 1 food nutritionist	Attendance n = 7 1 care aide 1 nurse 1 social worker 1 manager 1 client representative 1 quality officer 1 intern	Attendance n = 7 2 care aides 1 nurse 2 managers 1 quality officers 1 management assistant	Attendance n = 8 2 nurses 1 manager 1 client representative 1 quality officer 1 psychologist 1 work coach 1 project leader
Follow-up meeting					
Attendance n = 7 3 care aides 2 nurses 1 social worker 1 manager	Attendance n = 4 3 nurses 1 manager	Attendance n = 6 2 nurses 1 manager 1 client representative 1 intern 1 food nutritionist	Attendance n = 4 1 social worker 1 manager 1 client representative 1 quality officer	Attendance n = 5 3 care aides 1 manager 1 client representative	Attendance n = 8 2 nurses 1 manager 1 client representative 1 quality officer 1 psychologist 1 work coach 1 project leader

Annex 2. Code tree

0. **Overall impressions**.

- Context
- Setting
- Participant characteristics
- Group dynamics
- Moderator
- Process lead
- Interaction of moderator and process lead
- Facilities
- Time

- Disciplinary contributions
- Connection to other initiatives

1. **Quality meeting**

- ***Structure***
  - o Preparatory assignment
  - o Introduction
  - o Basic agreements
  - o Exchange
  - o Clustering
  - o Prioritization
  - o Stakeholders involved
  - o Areas for improvement and drafting action plan
  - o Closure of the meeting
- ***Content***
  - o From concrete towards abstract
  - o Exchange of perspectives
  - o Relationship original post-it and improvement action

2. **Follow up meeting**

- Summary and looking back
- Progress on action plan
- Linking back to original portraits
- Time between quality meeting and follow up meeting
- Postponed follow up meeting
- Follow up actions

3. **Outcomes**

- ***Individual learning***
  - o Change in way of thinking
  - o Increase in consciousness
- ***Collective learning***
  - o Team learning
  - o Learning from other disciplinary perspectives
  - o Appreciation shown for care aides
- ***Extra follow up meeting / cyclical process***

4. **Added value**

- ***For participants quality meeting***
  - o Richer understanding of client perceptions
  - o Jointly working towards concrete actions
  - o Educational and reflection
  - o Multidisciplinary company
  - o Nuanced and varied findings

- ***For interviewer***
- ***For client***

5. **Challenges**

- Time
- Ratio of revenues and costs
- Choosing the size of area for improvement

6. Conditions

- Reassuring anonymity
- Quality of portraits
- Embedding structurally
- Communication
- Verbally capable clients

Appendix C. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.nepr.2023.103659.

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