

SETTING GOALS, SHIFTING ROLES

GOAL-ORIENTED PRACTICE AS A PATHWAY
TO THE PROFESSIONAL DEVELOPMENT
OF NURSES IN GERIATRIC REHABILITATION



ANNE MARIE

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VRIJE UNIVERSITEIT

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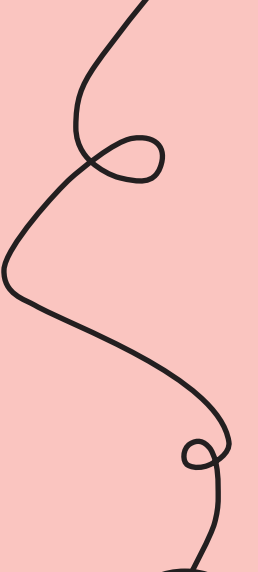
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CHAPTER

1

GENERAL INTRODUCTION

1 | GERIATRIC REHABILITATION

The ageing population in Europe has increased the demand for geriatric rehabilitation services that help older people with functional decline after medical events.¹ Achterberg et al.² point out two key ideas that drive the development of these services. The first is shortening hospital stays. This is important because hospital stays themselves often lead to further functional decline in older adults.³ Even after the reason for hospitalisation is resolved, patients are often discharged with a new major disability.⁴ The second idea is to help people remain in their homes as they age, which is what most of them prefer.⁵ Rehabilitation treatment for older adults might improve their functional status,⁶ thus preventing older people from being admitted to nursing homes. This not only save costs for long-term care but might also play a role in effectively maintaining quality of life in older adults.^{6,7} In 2019, 53,320 patients in the Netherlands were admitted to a so-called geriatric rehabilitation facility,⁸ 30 percent of whom because of trauma due to bone fractures and 17 percent after having experienced a stroke. Other reasons for admittance were COPD exacerbation, oncological diseases and treatment, and heart failure. According to the International Classification of Functioning, Disability and Health (ICF) framework of the World Health Organization (WHO) and the WHO rehabilitation cycle, geriatric rehabilitation is defined as a series of “diagnostic and therapeutic interventions, the purpose of which is to optimize functional capacity, promote activity and preserve functional reserve and social participation in older people with disabling impairments”.^{9(p234)} To professionalise geriatric rehabilitation further across Europe, Van Balen et al.¹ and Grund et al.⁹ set out to describe their core principles. For this thesis, we focus on the process of rehabilitation, in which goals are a central feature, and the geriatric rehabilitation team structure, of which nurses are part.

2 | GOAL SETTING AND ACHIEVING IN GERIATRIC REHABILITATION

To achieve the goal of optimizing functional capacity in older adults, geriatric rehabilitation employs goals as a tool to support a systematic approach to patient care. Grund et al.⁹ describe how a rehabilitation plan is set up through shared decision-making, containing goals based on a comprehensive geriatric assessment and at the same time incorporating the perspective of the patient and informal caregivers. The result is a plan with measurable and time-specific goals, with appropriate priority given to the preferences of the patient. Progress on the goals is regularly assessed in team meetings.⁹ According to a typology of purposes and mechanisms to clarify the use of goal planning in rehabilitation, four purposes can be distinguished^{7,10} 1) improving rehabilitation outcomes (as determined by standardised outcome measures); 2) enhancing patient autonomy; 3) evaluating the success of a rehabilitation programme by evaluating outcomes; and 4) responding to contractual, legislative or professional requirements. Our research is aimed at the first two purposes. By involving patients in shared goal planning with professionals, goals are likely to become more meaningful; the ‘meaningfulness’ of goals might influence a person’s motivation to participate in a treatment’,^{10(p743)} which in turn might lead to improved rehabilitation outcomes.

‘By focusing on patient participation as a strategy, a patient-centred approach is facilitated, and this will in turn lead to patient empowerment^{11in12(p1339)}, [...] the individual process of taking responsibility for one’s own health’.^{12(p1339)}

3 | THE NURSE AND THE MULTIDISCIPLINARY TEAM

Another central feature of geriatric rehabilitation described by Grund et al.⁹ and Van Balen et al.¹ is the geriatric rehabilitation team structure. The team should be composed of multiple disciplines, at least comprising a physician trained in geriatric rehabilitation, a physiotherapist and a nurse. Depending on the type of rehabilitation, occupational therapists, dieticians, psychologists and social workers can be added to the team. The nurse in this team has four key functions:¹³ the conserving function, which aims to ensure the best possible starting point for rehabilitation; the interpretive function, which helps guide patients through their current situation; the consoling function, providing emotional support; and the integrative function, through which nurses incorporate therapeutic techniques into care and other activities that are meaningful for the patient.¹³ In this way, the role of nurses may be a crucial factor in the success of rehabilitation.

The multidisciplinary approach involves building strong relationships between different professional groups, working together to put a comprehensive care plan into action, and promoting effective teamwork across disciplines.¹⁴ While collaborative teamwork is crucial for achieving quality rehabilitation outcomes,¹⁴ healthcare professionals often lack a clear understanding of each other’s roles and skills, and may not be fully prepared to work effectively in a multidisciplinary team.¹⁵ Nurses sometimes even lack a full understanding of their own role and what is expected of them,¹⁶ or underestimate the scope of their role in rehabilitation care.^{17,18} Also, De Vos et al.¹⁹ found that nurses experience a certain apprehensiveness about performing their tasks in the multidisciplinary team, while their contribution to patients’ rehabilitation and the setting and achieving of goals as a core process might in fact be pivotal because, of all multidisciplinary team members, they are most consistently present throughout the rehabilitation. A clearer understanding of their role and how this role matches rehabilitation patients’ needs is needed to strengthen their contribution to the multidisciplinary team.¹⁷ This is especially the case in the Netherlands, where geriatric rehabilitation mainly takes place within nursing homes. In the Netherlands, nursing staff in nursing homes consists not only of registered nurses but also largely of certified nursing assistants.²⁰ A considerable part of the training of certified nursing assistants is focused on providing comfort in an environment where older people live, as opposed to working in a multidisciplinary team with patients on the rehabilitation goals.

4 | LINKING PROFESSIONALISATION TO NURSE RETENTION

Staff shortages in geriatric care are expected to worsen in the coming years.²¹ Currently, the shortage of healthcare personnel in the Netherlands amounts to 16,100,²² while enrolment in nursing courses continues to fall.²³ During my work at the Dutch Nursing

Council V&VN from 2011 to 2019, I realised the importance of professional development in relation to retaining people in the profession. The work of V&VN was inspired by research by, amongst others, the American Academy of Nursing, into the connection between the work environment and staff retention. This research showed that job satisfaction is related to nurses being able to exercise autonomy over their own practice.²⁴⁻²⁶ Having a clear picture of this practice is crucial to exercising autonomy. Nurses in general, but also specialized nurses like geriatric rehabilitation nurses, need a shared understanding of their role and function. V&VN put and still puts much effort into establishing a common identity through the work on so-called areas of expertise²⁷ and through the description of acknowledged standards and guidelines.²⁸ A clear picture of one's role and related guidelines helps to achieve excellence in nursing. Working in an environment with colleagues that expect excellence will result in nurses adapting to the higher expectations, and that leads back to retaining nurses in the profession: the greatest sense of fulfilment comes from knowing you provided the highest quality care possible²⁹ (see Figure 1).

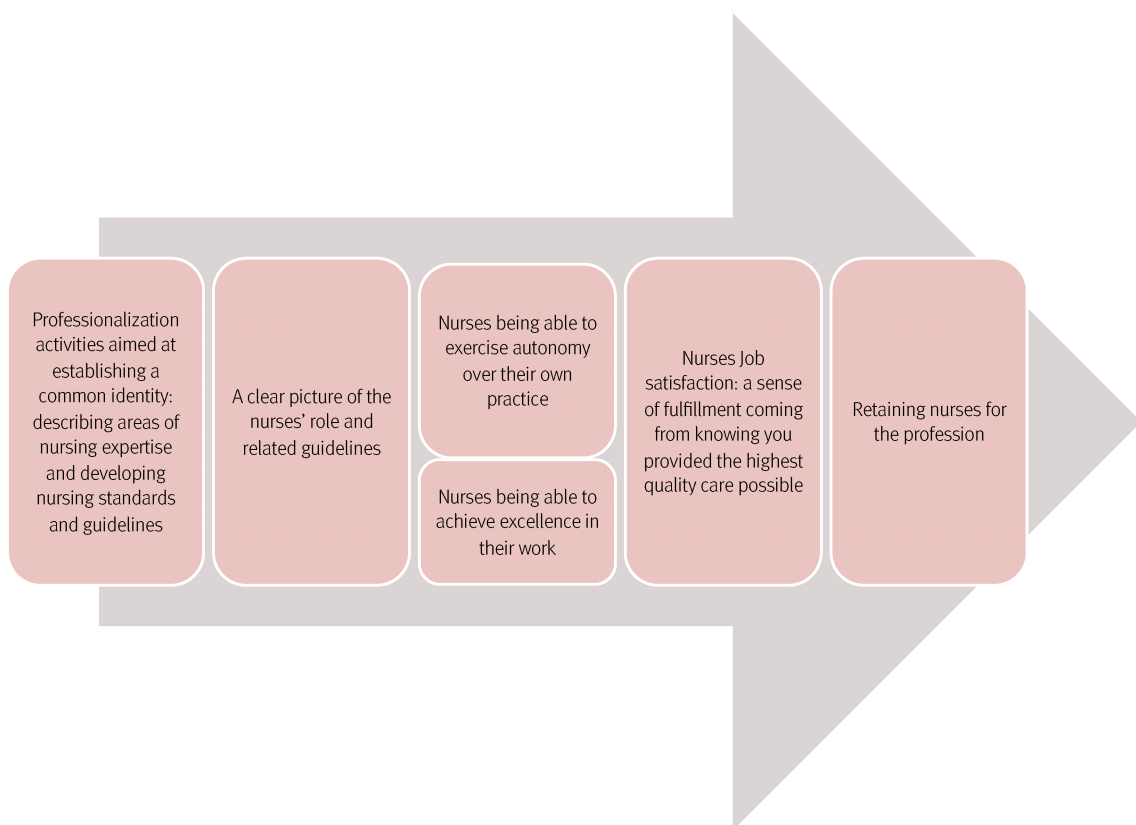


Figure 1. The link between staff retention and professionalisation.

5 | PARTICIPATORY ACTION RESEARCH IN A LEARNING AND INNOVATION NETWORK

In healthcare, the guiding principle in quality thinking is to improve care based on reflecting and learning together with those involved. Therefore, for a significant part of this study, participatory action research (PAR) was used as a method. In PAR, participants and researchers work together in a cyclical and self-reflective process to improve their practices.³⁰ This cycle allows them to try out strategies and then collectively assess the results through further research. Encouraging nursing professionals to take part in research helps create a culture of engagement and supports them in sharing their insights on effective practices. By collaborating, they gain valuable knowledge and expertise to address specific challenges in the field.³¹ Our aim was to enable a nursing team to refine their patient-centred strategies and, on a larger scale, to empower the nursing team in dealing with work issues chosen by themselves. To foster this process, the research took place in a learning and innovation network (LIN). In a LIN, with the aim of improving the quality of care and boost the learning climate on a ward, more nursing students than usual are added to the ward as interns. Nurses and nursing students work together on practice-based projects, constantly reflecting, learning and combining best practices, research evidence and patient perspectives.³² I was assigned to the LIN as a lecturer practitioner to facilitate the PAR process.

6 | AIM AND OUTLINE OF THIS THESIS

The overall goal of this research is to contribute to knowledge about nurses' role in geriatric rehabilitation by focusing on goal setting and achieving activities, in order to contribute to the professionalisation of the nursing profession in geriatric rehabilitation. The question we aimed to answer was:

How can the nursing profession contribute to goal setting and achieving activities in geriatric rehabilitation, and what does this reveal about their professional role within this context?

The following sections describe the sub-studies that contributed to this goal. The **second chapter** of this thesis presents a narrative review with two objectives. The first objective was to provide an overview of the experiences and ensuing needs of geriatric patients concerning goal setting, the second to ascertain if the needs of patients concerning goal setting could be met by the nursing profession in geriatric rehabilitation. Knowledge about this aspect of nursing care could strengthen the role of the nursing profession in geriatric rehabilitation and thus improve the goal-setting process for patients. The **third chapter** of the thesis presents a scoping review exploring the range of interventions on goal setting and achievement available to nurses in geriatric rehabilitation. An overview of these interventions, the specific goals they aim to achieve, the practices and materials they use, and the aspect of the nursing

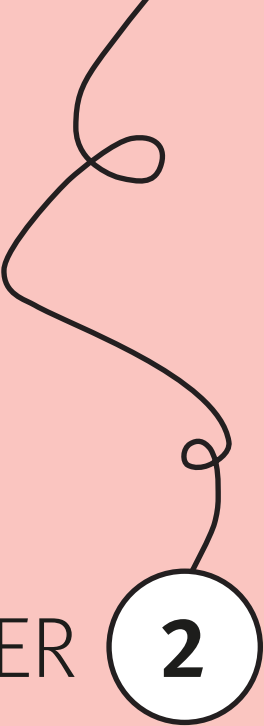
profession to which they appeal will help to provide a more accurate picture of nurses' ability to support older patients in working on goals. Subsequently, we designed a focus group study with geriatric rehabilitation nurses. With them, we explored some of the interventions, their underlying vision and the different components, aiming to clarify the nurses' role. This study is described in the **fourth chapter** of this thesis. **Chapter Five** is about the PAR on client-centred goal setting and achieving. The aim of this study was to provide insights into how, through exploring goal setting interventions, a nursing team in geriatric rehabilitation might refine their patient-centred strategies. The underlying vision of the PAR was that projects involving nurses will lead to more appropriate actions and offer the nursing team a greater sense of control. In **Chapter Six** we evaluate the process of involving nurses in this PAR and the facilitators and barriers that we observed. In **Chapter Seven**, the main findings are presented and discussed in a broader perspective; implications for practice and future research are summed up.

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CHAPTER 2

GOAL-SETTING IN GERIATRIC REHABILITATION: CAN THE NURSING PROFESSION MEET PATIENTS' NEEDS? A NARRATIVE REVIEW

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Lizette Wattel

Petra Boersma

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Nursing Forum. 2021

ABSTRACT

STUDY OBJECTIVE

To provide an overview of patients' needs concerning goal-setting, and indications of how those needs can be met by nurses.

METHODS

A narrative review. Pubmed and Cinahl were searched through March 1, 2020 for: patients' experiences concerning goal-setting and the role of nursing in rehabilitation. Additional articles were found through snowballing. A total of 22 articles were reviewed on patients' experiences, and 12 on the nursing role.

RESULTS

Patients need to be prepared for collaborating in goal-setting and receive an explanation about their part in that process. The multiplicity of disciplines may cloud patients' understanding of the process. The nurse's planning of the rehabilitation process should be aimed at resolving this issue. Goals need to be meaningful, and patients need support in attaining them. The interpretive, integrative, and consoling functions of Kirkevoll's nursing role are suitable to meet these needs.

CONCLUSIONS

Both the literature about patients' needs regarding goal-setting and the nursing role make clear that the way nurses work in rehabilitation can gain in clarity. Strengthening the role of nurses will improve the goal-setting process for patients. Interprofessional collaboration, clear work procedures, continuity of care, time and trust, and the physical environment all are important to reinforce this role.

1 | INTRODUCTION

Geriatric rehabilitation is a relatively new field in health care, aimed at persons over the age of 70 who still desire independence following a medical event, such as a hip fracture or stroke.¹ This fierce desire to be autonomous is evident in persons in many European countries and beyond. In the Netherlands alone, 52,000 people (of a population of 17 million) received geriatric rehabilitation in 2018.² International statistics are unavailable, but there is ample reason to suspect similar numbers in various countries.

The prerequisites for geriatric rehabilitation are not dissimilar to those for rehabilitation as a specialized field. The general focus of rehabilitation is also to improve ADL functions and social engagement/participation, and to improve the overall quality of life and well-being of those needing these services. In geriatric rehabilitation, the health team addresses multi-morbidities, delirium, and other complicating aspects of life, such as fragility, cognitive impairments, continence, gait, and balance problems.^{3,4}

A vital aspect of rehabilitation is to align the professional expertise of multi-professional providers with the goals and life aspirations and capacity of the person needing rehabilitation. Without this shared purpose, the feasibility of optimizing the patient's experience will fall short, resources will be squandered, and outcomes diminished.⁵⁻⁹ However, practicing patient-centered goal-setting remains a challenge.^{7,8,10-13} Smit et al.¹⁴ tested the feasibility of a new patient-centered goal-setting method for geriatric rehabilitation. They found that patients experienced that professionals determine the steps toward the discharge, and these steps were often not clear or transparent to them. To improve the collaboration process on goal-setting and goal-achieving and to increase patient participation and motivation, more knowledge is needed about patients' experiences and views of goal-setting and achieving. This information will help clarify the needs of patients with regard to working on goal-setting.

Further, the roles and functions of the nurses who intersect and integrate their practice within health disciplines that have less broad-based purposes is also unclear.^{15,16} Nurses experience a certain apprehensiveness about performing their tasks in the multidisciplinary team.¹¹ This can be due to absence of clear working procedures, lack of specific knowledge of frail elderly people, the variability of interdisciplinary teamwork and communication, or to patients' expectations that they be cared for instead of supported to practice self-care.^{11,15}

The twofold aim of this literature review is to analyze goal-setting and achievement from the vantage of the patient, with the specific aim of examining nursing roles in the process. Knowledge about this aspect of nursing care could strengthen the role of the nursing profession in geriatric rehabilitation and thus improve the goal-setting process for patients.

2 | METHODS

A narrative review was performed following the General framework of narrative reviews by Ferrari,¹⁷ first focusing on the international literature on patients' perceptions of goal-setting, and secondly on the nursing role concerning goal-setting in rehabilitation. To find relevant literature, we searched the databases Pubmed and Cinahl. The terms used in the search for patients' perceptions of goal-setting were goal setting, goal attaining, geriatric rehabilitation, and patients' experiences. The terms used in the search about the nursing role were nursing role, goal-setting and geriatric rehabilitation.

In both searches a substantial amount of articles were found through snowballing,¹⁸ which refers to using the reference list of a paper, the citations to the paper or the assigned keywords.¹⁹ One of the main reasons for this is that geriatric rehabilitation is a relatively new field in health care, and not a widely used concept internationally. We also added articles pointed out by colleague researchers. A key article was that of Smit et al.¹⁴ Because Smit et al.¹⁴ tested a method for goal-setting in geriatric rehabilitation, their paper was useful in the context of the first subject (patients' needs concerning goal-setting in geriatric rehabilitation). This article in particular led to relevant further articles. The same applies to the article of Loft et al.¹⁶: they studied the self-perceived outcome of an educational program for nurses on goal-setting, and gave insight into nurses' perceptions about their role in goal-setting.

A total of 22 articles on patients' experiences concerning goal-setting were reviewed (see Table 1). A total of 12 articles on the nursing role in geriatric rehabilitation were reviewed (see Table 2). Both the searches were completed on March 1, 2020.

Thematic analysis was applied to identify common themes in the literature.^{41,42} First, articles were thoroughly read at least twice (AV). Preliminary findings and ideas were coded. Codes were clustered and titled as themes (AV, RG). Subsequently a thematic map of the analysis was discussed and rearranged with the other researchers (CH, RG, PB, and EW). If present in the articles, quotes of patients were, after coding, added to the map, to support the debate.

Table 1. Studies on patients' experiences included in the review.

Authors, year, country	The objective of the study	Method	Participants	Setting
Davis ⁵ 2007 USA	To explore goal-setting and its influence on exercise motivation of people with COPD.	Assessment of motivation and goal orientation. Qualitative study (interviews about exercise and activity goals).	Fourteen patients, mean age 69.7	Community pulmonary clinics rehabilitation centers
Levack et al. ⁶ 2006 New Zealand	To determine the evidence regarding the effectiveness of goal planning in clinical rehabilitation.	Systematic review of 19 studies.	No	Rehabilitation
Plant et al. ⁷ 2016 UK	To identify barriers and facilitators to goal-setting during rehabilitation for stroke and other acquired brain injuries.	Systematic review and meta-synthesis of 9 studies.	Eighty-eight patients (stroke and other acquired brain injuries) Twenty-five relatives	Rehabilitation for stroke and other acquired brain injuries
Rose et al. ⁸ 2019 UK	To synthesize literature that considers the extent of shared decision making within goal-setting in rehabilitation settings, and explore participants' views of this approach within goal-setting.	Systematic review of 15 studies.	No	Rehabilitation setting
Turner-Stokes et al. ⁹ 2015 UK	To examine the relationship between patient/family engagement in goal planning, satisfaction with the goal-setting process, and associated goal attainment and functional gains during rehabilitation.	Prospective cohort analysis of consecutively completed episodes for patients discharged over 1 year.	Eighty-three adults with neurological disabilities Mean age 42.8	Specialist neurological rehabilitation service
Cameron et al. ¹⁰ 2018 Australia	To explore the ways clinicians engage rehabilitation patients in patient-centered goal-setting, and identify factors influencing the goal-setting process.	Qualitative study (transcripts of goal-setting interviews, focus groups).	Seventeen rehabilitation patients (stroke, amputation, post-orthopedic surgery, acquired brain injury) Mean age 57.6	Three general rehabilitation units

[continued on next page]

Table 1. [continued]

Authors, year, country	The objective of the study	Method	Participants	Setting
Rosewilliam et al. ¹² 2011 UK	To map out from the literature the nature, extent, and effects of the application of patient-centered goal-setting in stroke rehabilitation practice.	Systematic review and synthesis of the qualitative (18) and quantitative (8) and mixed-method (1) evidence behind patient-centered goal-setting.	No	Stroke rehabilitation
Sugavanam et al. ¹³ 2013 UK	To systematically integrate and appraise the evidence for the effects and experiences of goal-setting in stroke rehabilitation.	Systematic review of 17 studies.	No	Stroke rehabilitation
Smit et al. ¹⁴ 2018 The Netherlands	To explore the feasibility of Collaborative Functional Goal-setting (CFGS), i.e., using standardized functional measures to set and evaluate functional goals during geriatric rehabilitation.	Qualitative study (three medical professionals working in two geriatric rehabilitation wards were trained in CFGS. Both patients and professionals were interviewed at the end of the study).	Eight patients, mean age 77.	Two geriatric rehabilitation wards
Brown et al. ²⁰ 2014 New Zealand	To explore patient experiences of goal-setting, to further understanding of its application in practice.	Qualitative study (semi-structured interviews).	Ten patients Mean age 59	Post-acute stroke rehabilitation in four hospital-based multidisciplinary rehabilitation teams
Van Seben et al. ²¹ 2019 The Netherlands	To characterize how the rehabilitation goals of older patients change over time and to explore professionals' attitudes toward patient-centered goal-setting and their perspectives on rehabilitation goals.	Qualitative study.	Ten patients >80, Cardiovascular disease and fractures, Seven professionals.	Three geriatric rehabilitation centers
Playford et al. ²² 2000 UK	To explore the views of therapists, nurses and doctors working in a variety of rehabilitation settings on the goal-setting process.	Qualitative study (a goal-setting workshop).	Sixteen rehabilitation staff	Neurological rehabilitation unit, community stroke rehabilitation team, department of health care of the elderly

[continued on next page]

Table 1. [continued]

Authors, year, country	The objective of the study	Method	Participants	Setting
Timmermans et al. ²³ 2009 The Netherlands	An inquiry into skill preferences of persons after stroke regarding arm-hand training and examining the relationship between the use of the affected arm and the patient's training preference.	Cross-sectional survey involving a semi-structured interview.	Twenty patients in the subacute stage after stroke, Twenty patients in the chronic stage after stroke. Mean age 61	Rehabilitation center
Van de Weyer et al. ²⁴ 2010 UK	To explore rehabilitation professionals' perspectives about goal-setting, and the use of two specific forms of goal-setting used within the same setting; "usual participation" and "increased participation."	Qualitative study (focus group interviews).	Fifteen rehabilitation professionals representing five different professions (speech and language therapist, occupational therapist, physiotherapist, nurse, doctor, student (occupational therapist)).	Neurological rehabilitation unit
Rosewilliam et al. ²⁵ 2016 UK	To explore whether goal-setting for rehabilitation with acute stroke survivors is patient-centered, and identify factors that influence the adoption of patient-centeredness in goal-setting practice.	Qualitative study (multiple methods).	Seven patients, mean age 64.	Specialized stroke ward
Rose et al. ²⁶ 2017 UK	To assess the extent of shared decision making (SDM) within goal-setting meetings, and explore patient-reported factors that influenced their participation in SDM about their goals.	Quantitative study (data collection with a multifocal approach to sharing in shared decision making (MAPPIN'SDM) questionnaire, shared decision making rated by an observer, patients and staff and compared, semi-structured interviews).	Forty patients, mean age 83. Frailty syndrome as defined by British Geriatric Society	Two intermediate care rehabilitation settings
Joseph-Williams et al. ²⁷ 2014 UK	To systematically review patient-reported barriers and facilitators to shared decision making, and develop a taxonomy of patient-reported barriers.	Systematic review and thematic synthesis of 45 studies.	No	Primary, secondary and community care

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Table 1. [continued]

Authors, year, country	The objective of the study	Method	Participants	Setting
Lloyd et al. ²⁸ 2014 UK	To investigate physiotherapists' perceptions about their experiences of collaborative goal-setting with patients in the sub-acute stage after stroke.	Qualitative study (semi-structured interviews).	Nine physiotherapists	Hospital
Holliday et al. ²⁹ 2007 UK	To examine the impact of an increased participation goal-setting protocol.	Qualitative study (comparison of <i>usual participation</i> with <i>increased involvement in goal-setting</i> through a qualitative research design).	Twenty-eight patients Mean age 49(stroke, multiple sclerosis, subarachnoid hemorrhage, Guillain-Barré Syndrome and spinal cord lesion).	Neurological rehabilitation unit
Bendz ³⁰ 2003 Sweden	To highlight ways in which people hit by a stroke and their health care professionals understand the implications of having a stroke.	Qualitative study (interviews and transcripts from the health care professionals' recording).	Fifteen patients	At home
Holliday et al. ³¹ 2007 UK	To explore how inpatients experienced two different types of goal-setting, and identify the issues that underpin individuals' experiences of goal-setting.	AB balanced block design controlled study.	Two hundred and one patients	Neurological rehabilitation unit
Poulin et al. ³² 2018 Canada	To understand how frailty impacts goal-based care planning in regional geriatric services.	Qualitative study.	Ten geriatric clinicians with diverse health professional backgrounds	Five different geriatric services

3 | RESULTS: PATIENTS' NEEDS

3.1 | PATIENTS' NEEDS CONCERNING GOAL-SETTING

The first objective of this analytic review was to provide an overview of the experiences of patients concerning goal-setting. Table 1 presents a list of the 22 articles reviewed. From patients' experiences, certain needs can be distilled. Four themes emerged from the review: goals need to be personally meaningful, patients need to be prepared for the goal-setting process, patients need information about their contribution to the collaborative process, and they need support in goal attainment through a customized approach.

3.2 | GOALS NEED TO BE PERSONALLY MEANINGFUL

Patients and professionals differ in the way they look at recovery.^{7,12,20} Professionals approach it by setting measurable goals, often related to physical progress in a defined period of time, while patients think more in the long term, with less precise objectives like "back to how I was before the stroke" or "getting better."^{5,9,20–22} While clients' motives for skill training are driven by the wish to participate in society, professionals focus on decreasing impairment; therefore, their goals are less meaningful to patients.²³ Patients will be motivated to do walking exercises when they apply it to their future hopes and dreams, for example being able to purchase a postcard from a museum for a relative, or in the example of grasping, being able to roll a cigarette.^{23,24} Rosewilliam et al.²⁵ state that patient-centeredness in goal-setting is uncommon, and that working with formal assessments and a hurried approach, focused on short term goals achievable during the hospital stay, hinders exploration of the patient's preferences. According to Van de Weyer et al.,²⁴ patients need a goal-setting approach that allows more participation than usual to enable them to have a stronger voice in the rehabilitation process. Timmermans et al.²³ suggest that this starts with a client-centered assessment. Thus patients' desires and aspirations will be better recognized.

3.3 | PATIENTS NEED TO BE PREPARED FOR THE PROCESS

Patients perceive that they do not have enough information about goal-setting and rehabilitation options to effectively participate in decisions about goals.^{12,20,25} When the patient is invited to goal-setting discussions by various individuals within the multidisciplinary team, it can be challenging for the patient to untangle the situation they find themselves in, and to know to whom to address questions and with whom to talk about progress.¹⁰ Patients need an explanation regarding the process of goal-setting to be prepared for this shared decision making process.^{7,8,12,13,26} Patients interviewed by Rose et al.⁸ experienced difficulty following communication about goal-setting; they struggled to follow the conversation, causing them to forget the topics discussed.

3.4 | PATIENTS NEED INFORMATION ABOUT THE COLLABORATIVE PROCESS

Generally, patients are inclined to accept the goals professionals set for them, because they see them as experts. They feel that through lack of medical knowledge they cannot

play an equal part in the goal-setting process.^{7,20,25–28} Also, patients interviewed by Plant et al.⁷ pointed out that in the initial stage of their rehabilitation, the goals they would like to work on are quite obvious, and hence, do not need to be elaborately negotiated between professional and patient. A qualitative study by Van Seben et al.²¹ confirmed this, as during inpatient rehabilitation, patient goals are mainly related to regaining independence in self-care activities. Patients do not recognize the complementary expertise about personal preferences and circumstances that they have.²⁷ When input is requested from patients on their personal wishes, experiences, and preferences, shared decision making is fostered.^{26,27} This lack of clarity as to what is expected from them in the process of collaborative goal-setting might result in a passive attitude, mistakenly understood by professionals as unmotivated behavior.^{8,12} The way patients want to be involved in goal-setting varies from individual to individual.¹⁴ This is partly because of personal preferences concerning involvement in goal-setting, but also because of the uncertain nature of recovery.^{7,20,29}

3.5 | PATIENTS NEED TO BE SUPPORTED IN GOAL ATTAINMENT

An important purpose of the collaboration on goals is to enhance patients' engagement in rehabilitation and to improve their task performance.^{7,13} To achieve this, more focus needs to be put on goal achievement. Some patients undertake certain activities aimed at fulfilling their hopes and dreams, but these are hardly ever measurable or time-bound.^{5,20} Davis⁵ interviewed fourteen COPD patients on their activity and exercise goals. The majority of the patients readily listed activity goals, but they gave no indication that they were appropriately exercising to accomplish these goals. Patients interviewed by Loft et al.³³ positively mention being given exercises for self-training, but their motivation to work toward goals was hampered by the nursing staff's lack of involvement and support. Davis⁵ and Rosewilliam et al.¹² stated that clinicians overestimate patients' ability to work purposefully on activity goals by exercising without the help of clinicians. Action planning, agreeing on a course of action to achieve short-term goals, addressing details such as what and how often, can structure and clarify the rehabilitation process for patients and their families. Turner-Stokes et al. call it: "an educational process in which patients and their families are engaged (...) in taking responsibility for monitoring, achieving, and re-setting goals along the journey of their recovery."^{9(p210)} Patients need a customized approach. Some patients flourish by small attainable goals, enabling their confidence to increase.^{7,20} Others need large, ambitious goals to get motivated; there are even patients who like to keep their goals to themselves.²⁰ When it comes to working with time-schedules, for some patients, they are useful, while others get nervous. Setting unrealistic goals needs to be avoided, and furthermore, patients and professionals need to be continually considering and reconsidering what can be worked on, what has gone well and what impeded progression.⁷ People's mental state should also be taken into account, as patients can, for example, suffer from fatigue or have fear of recurrence of their disease. Also, patients' emotional and social needs are not explicitly incorporated into, or may even be overlooked in goal-setting processes.^{25,30}

4 | RESULTS: THE NURSING ROLE

The second objective of the analysis was to find out if patients' needs concerning goal-setting could be met by the nursing profession. Table 2 presents a list of the 12 articles reviewed. Not all articles go into goal-setting directly; some approach the subject from a less practical, more abstract level. However, goal orientation can be seen as the foundation of all nursing,^{34–36} which means, “the patient, family members, and professional staff together evaluate the patient’s situation and set out goals for recovery, accept those goals, work toward them and evaluate results and aims.”^{35p211}

The theoretical framework of Kirkevold,³⁷ which described the nursing role in stroke rehabilitation, was referred to in many of the found articles.^{34–36,38,39} Kirkevold described the role in four functions: the interpretive, the consoling, the conserving and the integrative function. All functions elaborated in Kirkevold’s framework,³⁷ except the conserving function, shine a light on the nursing role concerning goal-setting. The conserving function is about meeting the patient’s basic needs and preventing complications like pressure sores, obstipation, and nutritional deficits. Providing a safe environment, a pivotal aspect of nursing according to Suter-Riederer et al.,³⁶ can also be seen as part of the conserving function. These activities are often not regarded as contributing to rehabilitation outcomes, however, they warrant an optimal starting position for rehabilitation therapies.³⁷

4.1 | THE INTERPRETIVE FUNCTION

Through the interpretive function, the nurse helps the patient understand what is the matter, what has to be done, and what the possibilities and impediments are, and makes patients aware of what rehabilitation requires from them, meanwhile encouraging patient and family not to lose hope for recovery.^{34,37} The main goal of this function is increased understanding of the situation on the patient’s part.³⁷ Rose et al.⁸ sum up several activities nurses can undertake: explain the word “goal,” explain what a goal-setting meeting will entail and what the patients’ role can be in the meeting, help the patient break down long-term goals into smaller goals, help them set their agenda for exercises, summarize the content of discussions, and many more supporting and educative activities. Various articles emphasize the need to involve the family in this process.^{4,33,35} Families need: “knowledge, support, and an active role.”³⁵

4.2 | THE INTEGRATIVE FUNCTION

The purpose of the integrative function is to help patients improve their daily functioning. Nurses integrate exercises in their daily work with the patient.³⁷ They do this by applying a facilitating and motivating attitude, working with their hands behind their back.^{4,38} Buijck et al.⁴ and Tijssen et al.³ confirm the important role of nurses in creating opportunities to practice outside regular therapy sessions. Because nurses see older rehabilitation patients 24 hours a day, they are in an important position to

Table 2. Studies on the nursing role included in the review.

Authors	The objective of the study	Method	Participants	Setting
Tijssen et al. ³ 2019 The Netherlands	To explore and describe the principles of Challenging Rehabilitation Environment.	Narrative review of 51 studies	No	Geriatric rehabilitation
Buijck et al. ⁴ 2018 The Netherlands	Not applicable*	“Therapeutic Climate,” a chapter from <i>“The Challenges of Nursing Stroke Management in Rehabilitation Centres.”</i>	Not applicable	Stroke rehabilitation
Loft et al. ¹⁵ 2017 Denmark	To explore nurses’ and nurse assistants’ beliefs and actions related to role and function in an inpatient stroke rehabilitation unit.	Qualitative study (participant observation and semistructured interviews).	Nurses (<i>n</i> =8) and nurse assistants (<i>n</i> =6).	Inpatient stroke rehabilitation unit
Loft et al. ¹⁶ 2018 Denmark	To assess nursing staff members’ self-perceived outcomes related to their capability, opportunity and motivation to work with a rehabilitative approach after participating in the stroke rehabilitation 24/7 educational program.	Convergent mixed-method design, consisting of a survey and semi-structured interviews.	Thirty-three nurses filled in a questionnaire, Ten nurses were interviewed.	Fifteen-bed acute stroke unit
Loft et al. ³² 2017 Denmark	To describe patients’ experiences with inpatient stroke rehabilitation and their perception of nurses’ and nurse assistants’ roles and functions during hospitalisation.	Qualitative study (interviews).	Ten stroke patients.	Stroke rehabilitation unit in a university hospital
Elo et al. ³⁴ 2012 Finland	To describe gerontological rehabilitation nursing in an acute hospital setting from the nursing staff’s points of view.	Cross-sectional design was used.	Registered nurses (RNs) and practical nurses (PNs) (<i>n</i> = 367) from four different hospitals responded to the questionnaire.	Gerontological rehabilitation in an acute hospital setting

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Table 2. [continued]

Authors	The objective of the study	Method	Participants	Setting
Routasalo et al. ³⁵ 2004 Finland	To describe the development of a geriatric rehabilitation nursing model on the basis of the nursing and rehabilitation literature.	Literature review of 120 studies.	No	Geriatric rehabilitation
Suter-Riederer, et al. ³⁶ 2018 Switzerland	To develop a common understanding of rehabilitation nursing care in Switzerland.	Delphi study	Fifty-four rehabilitation nursing stakeholders.	Neurorehabilitative settings
Kirkevoid ³⁷ 2010 Norway	To propose an extended theoretical framework of the role of nursing in stroke recovery and rehabilitation.	The theoretical account is based on a review of recent research on stroke nursing and on patient experiences of living through the adjustment and rehabilitation process following a stroke.	No	Stroke rehabilitation
O'Connor ³⁸ 2000 UK	The aim of this study is to demonstrate that the perspective of a nurse's role in acute stroke rehabilitation should include a reference to the manner in which the functions (Kirkevold) are delivered.	Results from a recent study of nurses' and patients' perceptions of the nursing care in stroke units are used to demonstrate the mode of delivery of care that is required for the nurse's rehabilitative function to be fulfilled.	No	Stroke rehabilitation
Pryor et al. ³⁹ 2009 Australia	To explore nurses' understanding and expectations of rehabilitation and nurses' perceptions of patients' understanding and expectations of rehabilitation.	Qualitative study (interviews and observations).	Fifty-three nurses.	Five health care units in regional Australia providing rehabilitation and aged care/geriatric assessment services
Sharp et al. ⁴¹ 2016 Australia	To examine acute nursing care from the perspective of the person receiving the care, and then to interpret the meaning of this care in relation to the concept of person-centered care (PCC).	Qualitative study (semi-structured interviews).	Ten former patients of an Australian regional health service.	A range of services, including mental health, oncology, and acute medical and surgical services

*study book

Table 3. Kirkeveld's functions matched with patients' experiences.

Patient's experiences	Nursing Role using Kirkeveld's functions as a framework
Goals should be meaningful <i>"I am a Jehovah's witness and I always practiced door-to-door evangelism . . . I hope it will get better soon, because having a curved back while standing at people's door is embarrassing."</i>^{21(p33)} <i>"How could they prepare me for coming home, they don't know about my home life ... they certainly don't go over and above what they're meant to be doing, which is looking after you from a medical point of view."</i>^{20(p1023)}	Integrative function: <i>"These are complex situations where the focus is split between correct performance and the accomplishment of specific daily tasks and meaningful activities. Unless patients are able to see the relevance of the newly learned techniques for performing activities of importance, the specific rehabilitation goals identified by professionals lose their meaning and motivational power."</i>^{37(p29)}
More info about process <i>"The goal-setting meeting yesterday was a lot better compared to in hospital. At least I knew what was going on and how they are going to help me."</i>^{8(p7)} <i>"What kind of goals? I am not that young you know..., no one's asked me. Apart from you ... if I leave here I have to go and sort out myself, my way."</i>^{25(p514)}	Interpretive function: <i>"Making sense: Patients need help to interpret the situation by being provided with realistic and individually adjusted information to create a meaningful understanding of the situation."</i>^{37(p29)}
More info about contribution to goal talk <i>"The practitioner was seen as the expert and the participant accepted the direction they provided because it was 'just assumed they knew their job' (Janet). 'I was the novice,' commented Ian, 'and they were the professionals.'"</i>^{20(p1023)}	
More emphasis on achieving goals <i>"I would have preferred them to break things down more ... to help me understand how I could achieve going home and being independent. It is hard to understand what I need to do to achieve this."</i>^{8(p8)} <i>"I used to be quite scared about the future and didn't want to think about it much, I thought 'What's the point?' There was too much to sort out. My goals seemed to break it all down so I could do it."</i>^{29(p392)}	Integrative function: <i>"A hallmark of the nurses' function and role was that they were always one step ahead; they were coordinating, planning and maintaining an overview of the rehabilitation process."</i>^{15(p4909)} Console and motivate: <i>"Consoling may also be needed to meet and endure the unpredictability and insecurity associated with the recovery process in order to maintain or instill hope and to encourage the motivation and hard work needed to regain as much functioning as possible."</i>^{37(p29)}

assess their possibilities of coping independently with essential tasks.³⁴ The integrative function entails applying the techniques of therapy in the care of the patient,^{15,43} but also helps nurses transfer the techniques to other meaningful activities.³⁷ Subsequently, an effective principle of nursing intervention is the transformation of therapeutic outcomes into daily life. Nurses tailor their interventions toward the patients' preferences to enhance functionality and meaningfulness.³⁶

4.3 | THE CONSOLING FUNCTION

Through the consoling function, nurses provide emotional support, are present, and acknowledge the difficulties of the affected patients;³⁷ a change of health status can easily cause a sense of helplessness in older people.³⁵ Recognizing patient suffering, facilitating compassion, appreciating patients' individuality, and focusing on solutions are key principles of person-centered care.⁴⁰ Emotional support is needed to instill hope and to encourage motivation.^{33,34,37} For the consoling function, a close and trusting relationship is needed.³⁷

4.4 | KIRKEVOLD'S FUNCTIONS MATCHED WITH PATIENTS' EXPERIENCES

Table 3 matches Kirkevold's functions with patients' experiences.³⁷ The interpretive function is mainly educational, giving information concerning the path to recovery, thus meeting the need of patients to be prepared for the process of goal-setting and achieving. Through the integrative function, the nurse translates skills from exercise sessions to everyday situations. Thus exercise sessions become meaningful activities and can, for example, be integrated into social activities.³⁸ Through the integrative function, they can also support goal attainment. Loft describes this as the hallmark of the nurse's function: "always being one step ahead, coordinating, planning, and maintaining an overview of the rehabilitation process."^{15p4909} Through the consoling function, nurses provide emotional support, known as soft rehabilitation.³⁴ The nurse supports the hard work that is needed to attain rehabilitation goals and recover as much as possible, and does this in a way customized to the patient's personality and preferences.

5 | DISCUSSION

The first objective of this study was to provide an overview of the experiences and ensuing needs of patients concerning goal-setting. Four aspects of the collaboration on goal-setting and achieving can be improved: goals need to be personally meaningful; more guidance is needed for patients to optimally collaborate in the goal-setting process; when patients are invited to be involved in goal-setting discussions, it should be explained that input is requested not on medical aspects but on personal preferences and circumstances; finally, more emphasis should be put on the process of goal-achieving.

The second objective of this study was to find out if the needs of patients concerning goal-setting could be met by the nursing profession in geriatric rehabilitation. Kirkevold's functions of stroke nursing served as a framework for this inquiry.³⁷ Several functions meet the patients' needs adequately, so by strengthening the nurses' contribution to the multidisciplinary teamwork, these aspects of the collaboration on goal-setting and achieving could be improved. Table 3, however, also uncovers two gaps. First, answering the need of patients to be informed about their contribution to the setting of goals is not described as part of the nursing role in any of the found articles. This might reveal that clinicians have a blind spot for this aspect of shared decision making. More knowledge is needed about that part of the nursing role, because functional goals can only be translated into meaningful goals if patients participate in the goal talk, adding their personal preferences. Second, although the integrative function concerns planning and coordinating the rehabilitation process, none of the authors touch upon the question of whether the nurse does this solely to structure his or her own work or also for the benefit of the patient's understanding of the process. We recommend further research on this topic. Additionally, the literature reveals certain barriers and facilitators for nurses to optimally play their role in setting and achieving goals with patients in general, and specifically in the above-mentioned two gaps: interprofessional collaboration, clear work procedures and materials, continuity, time and trust, and the physical environment all make an impact.

The multiplicity of disciplines, a strength of interprofessional collaboration in the geriatric rehabilitation practice, can become a weakness, as the multiple messages may cloud the patients' understanding of the process, particularly considering the cognitive frailty of the patients.⁹ Patients are not aware that rehabilitation is a 24/7 process. They distinguish rehabilitation care, provided by, for example, physiotherapists, from nursing care.^{11,15,39} The use of overarching patient-centered goals is an answer to this barrier; it unites team members around a shared purpose rather than pursuing separate discipline-specific activities.^{28,43–45} This shared planning and delivery supports nurses in their interpretive and integrative function, and additionally, it facilitates interprofessional learning.^{45,46}

Clear working methods when it comes to goal-setting are also mentioned as a prerequisite for nurses to play their role,¹¹ clear, simple elements that can be embedded in the daily routine of all staff members, which will improve the interpretive and integrating role of the nurse. Subsequently, these will help patients play an active role in their own rehabilitation, both in setting goals and in customizing them to their personal needs and working toward achieving them.^{31,32,46}

Goal-setting has proven to be a process driven by professionals aimed at preparing patients for discharge. Several studies^{7,8,12,26} recommend working with supporting material: pictures of goals, lists of examples of goals, exercise plans divided into

stepping stones, worksheets, explicit methods of patient involvement, the care plan as a shared document with which to follow progress, exercise books. According to Plant et al.,^{7(p.926)} “participants felt these tools help to clarify expectations, guide patient-led therapy, enable progress to be monitored and facilitate family involvement.” Which criteria these methods and materials should meet to support patients’ needs and to fit into the nursing routine is an important area for further study.

Another condition nurses mention is lack of continuity in care, caused for example by working in shifts and by lack of consistent patient assignment to nursing team members.^{7,13} Related to continuity, time is also mentioned as a prerequisite for optimal collaboration on goals between clinicians and patients.^{7,12,25,26} Time and continuity are crucial prerequisites for building a relationship and thus for gaining knowledge about patients’ preferences, concerns, goals and progress to optimally guide them through their process of recovery.^{15,36} Finally, the physical environment in the ward is described as a facilitator.^{3,15} Loft et al.^{15p4911} illustrated this with a ward in which there were only two bathrooms: “nurses and nurse assistants choose to wash and dress the patient in their room because they could not wait for the bathroom to become available, and the patient consequently missed the opportunity to practice....”

5.1 | STRENGTHS AND LIMITATIONS

This study contributes to the clarification and strengthening of the nursing role concerning goal-setting in the multidisciplinary team—an important subject, given the fact that the population is aging and more elderly will need support to return to their homes in the best possible condition. Gaps in nurses’ role were revealed, as well as facilitators and barriers to filling in these gaps adequately. The limitation of a narrative review is that it lacks an explicit intent to maximize scope.⁴⁷ The conclusions we have drawn could be biased from the fact that, inadvertently, significant sections of the literature have been missed, or from the fact that the validity of statements have not been questioned.⁴⁷ Another risk on bias is that the articles were selected by one researcher. Nonetheless, the literature reviewed unambiguously emphasized that patients need to be guided in or educated about the process of goal-setting. A considerable amount of the literature focusses on patients who have experienced a stroke, a patient group with exceptionally challenging conditions, such as cognitive and communicative problems, the sudden onset of the disease and the trauma these aspects of the disease cause. This might influence the outcome of this narrative review. On the other hand, 16% of the population in geriatric rehabilitation are stroke patients, and like stroke patients, geriatric patients are frail and often cope with cognitive problems.⁴⁸

6 | CONCLUSION

Because setting goals is primarily an activity initiated by professionals and not a natural way of working at recovery for patients, patients need an explanation about the process and their role in it, the latter to ensure that set goals are meaningful for patients. Both the literature about patients' needs as regards goal-setting and the literature about the nursing role in rehabilitation make clear that the way we work in rehabilitation can gain in clarity. Talking about and being occupied with (achieving) goals should determine the daily routine in geriatric rehabilitation. For nurses to perform these functions, working on shared patient-centered goals in the multidisciplinary team is a central issue. Second, clear work procedures and material should support the collaborative process of "goal-talk" and increase the transparency of the rehabilitation process and its possibilities. Third, continuity of care is important to build a relationship of trust within which patients are invited to share their personal preferences. Further, the physical environment needs to be optimal for integrating exercises into daily care.

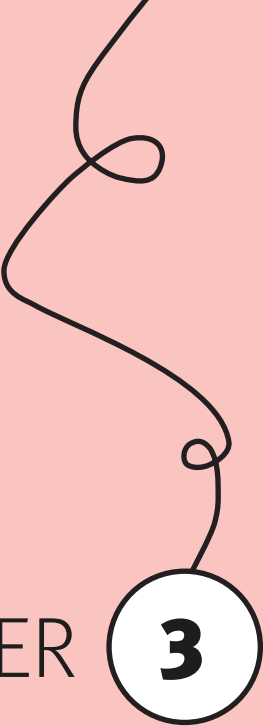
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CHAPTER 3

SUPPORTING OLDER PATIENTS IN WORKING ON REHABILITATION GOALS: A SCOPING REVIEW OF NURSING INTERVENTIONS

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ABSTRACT

BACKGROUND

Nurses are consistently present throughout the rehabilitation of older patients but are apprehensive about performing goal-centred care in the multidisciplinary team.

OBJECTIVES

The aim of this review was to explore working interventions on setting goals and working with goals designed for nurses in geriatric rehabilitation, and to describe their distinctive features.

METHODS

We performed a scoping review. We searched MEDLINE and CINAHL through August 4, 2021. Search terms related to the following themes: nurses, rehabilitation, geriatric, goal and method. We used snowballing to find additional studies. From the selected studies, we systematically extracted data on means, materials and the nursing role and summarised them in a narrative synthesis, using intervention component analysis.

RESULTS

The study includes 13 articles, describing 11 interventions which were developed for six different aims: improving multidisciplinary team care; increasing patient centredness; improving disease management by patients; improving the psychological, and emotional rehabilitation; increasing the nursing involvement in rehabilitation; or helping patients to achieve goals. The interventions appeal to four aspects of the nursing profession: assessing self-care skills incorporating patient's preferences; setting goals with patients, taking into account personal needs and what is medically advisable; linking the needs of the patient with multidisciplinary professional treatment and vice versa; and thus, playing an intermediate role and supporting goal achievement.

CONCLUSIONS

The interventions show that in goal-centred care, the nurse might play an important unifying role between patients and the multidisciplinary team. With the support of nurses, the patient may become more aware of the rehabilitation process and transfer of ownership of treatment goals from the multidisciplinary team to the patient might be achieved. Not many interventions were found meant to support the nursing role. This may indicate a blind spot in the rehabilitation community regarding the additional value of its contribution.

1 | INTRODUCTION

Patients are experts on their own situations, and their participation in their treatment is considered as playing a vital role in their treatment's success.¹ In geriatric rehabilitation, we use joint goal setting between patient and medical professional as a means to encourage patient participation. It will support patients to move from being a passive recipient of care to an active participant in their own rehabilitation process.² In addition, joint goal setting might improve patient's motivation to engage in therapeutic activities.³

However, for many older patients, formal goal setting is an unusual activity. Vaalburg et al.⁴ disclose several needs of older patients concerning the setting and achievement of goals: goals need to be meaningful, patients need to be prepared for the process, patients need explanation about their role in the process of setting goals and there should be more emphasis on goal achieving. Developing working interventions and interventions that answer these needs and support effective partnership is important.⁵

Nurses, as members of the multidisciplinary team, are most consistently present throughout the rehabilitation. Kirkevold⁶ describes their contribution to the rehabilitation in four functions: the conserving function—intended to ensure the healthiest possible starting position for rehabilitation; the interpretive function—deployed to guide patients through the situation in which they have ended up; the consoling function; and the integrative function—through which the nurse transfers the techniques of therapy into the care and into other, for the patient, meaningful activities.⁶ As such, the performance of nurses might be a key factor for successful rehabilitation.

However, according to De Vos et al.⁷ nurses experience a lack of confidence in performing their tasks in the multidisciplinary team. One might attribute this to a knowledge gap when it comes to frailty in older people, the specific requirements of interdisciplinary teamwork and communication, to patients' expectations of nurses caring for them rather than being actively involved in rehabilitation and to an absence of clear working interventions^{7,8}. As long as their share in the rehabilitation process remains unclear, the nurses' role in goal setting and achieving with older people will correspondingly remain undefined.

Cameron et al.⁹ indicate that there is a need for interventions for goal setting and achieving if nurses are to play a role in this area. Interventions that are closely linked to the nursing profession and to the multidisciplinary nature of geriatric rehabilitation will strengthen the interpretive and integrative side of its work. As a result, this will help older patients to play an active role in a rehabilitation process that is as much as possible attuned to their personal lives and needs.¹⁰⁻¹²

Therefore, the aim of this study was to explore the range of interventions on goal setting and achieving available to nurses in geriatric rehabilitation and to describe their distinctive features. An overview of these interventions, of the specific goals they aim to achieve, of the practices and materials they use and of the aspect of the nursing profession they appeal to, will help to provide a more accurate picture of nurses' ability to support older patients in working on goals.

2 | METHOD

For this study, we chose to conduct a scoping review. According to Peters et al.,¹³ scoping reviews are particularly appropriate when literature is heterogeneous. They are helpful to identify, map and discuss the characteristics of a concept and we can use them to advance the field.¹³ We followed the methodological framework developed by Arksey and O'Malley¹⁴ containing five stages: (1) identifying the research question, (2) identifying relevant studies, (3) selecting studies, (4) charting the data, and (5) collating, summarising and reporting the results.

JK and AMV performed the search for articles (stage 3) using the databases MEDLINE and CINAHL; they did not limit the search with any time restrictions and they completed it on August 4, 2021. Search terms related to the following themes: nurses, rehabilitation, geriatric, goals and intervention. We have provided the search terms and strategies in Appendix 1. We found additional articles through snowballing, which refers to using the reference list of a article, the citations to the article or the assigned keywords. The criteria for inclusion of the articles were that the interventions had to be, if stated, aimed at older persons (≥ 65 years) and that they described interventions concerning goal setting or goal achieving in physical rehabilitation and not cognitive rehabilitation, (however, in line with European consensus about the selection of patients for geriatric rehabilitation described by Van Balen et al.,¹⁵ articles including patients with confusion/delirium or cognitive decline were not excluded); interventions had to be applicable in inpatient rehabilitation settings or starting in the inpatient setting and continuing at the patient's home; described interventions were applicable to the nursing profession; described interventions preferably had a name but in the least listed distinguishable steps and were published in English or Dutch.

Stage 4, charting the data, was done through an intervention component analysis,¹⁶ consisting of two steps, the first of which we followed. This step consists of understanding the characteristics of included interventions in detail, if necessary contacting authors to clarify details. Two reviewers (AMV, PB) screened the articles to determine which intervention components to extract, AMV, PB, EW, CH and RG developed a data chart and continuously updated it in an iterative process. To ensure reliability of the results, two reviewers (AMV, PB) independently analysed the first five articles (30%) and AMV subsequently analysed the remainder. AMV and PB analysed three intervention components: firstly, the purpose for which the intervention is

designed; secondly, the means by which it seeks to achieve that purpose and as a specification of this point, we reviewed the materials used in the found interventions; and thirdly, the nature of nursing involvement in the interventions.

Additionally, this step in the intervention component analysis consists of an ‘effectiveness synthesis’ identifying the success and failures of individual studies.¹⁶ This synthesis includes a broader view of evidence, differing from the approach in a systematic review. Alongside the described impact of the interventions, the reflections of the authors in the discussion sections of the trial reports were also considered (see Table 1, last column). The underlying idea is that through this we can learn from valuable experiential knowledge.

3 | RESULTS

We identified a total of 915 articles. After screening the titles, abstracts, full texts and correcting for duplicates, 13 articles met the inclusion criteria, describing in total 11 interventions (Figure 1). Table 1 provides a description of the study characteristics.

3.1 | PURPOSE OF THE INTERVENTION

Table 2 presents a description of the interventions. The interventions found were developed with six different aims: improving multidisciplinary team care, increasing patient-centredness, improving disease management by patients, improving the psychological and emotional rehabilitation, increasing the nursing involvement in rehabilitation and/or helping patients to achieve goals. Three interventions aimed to improve multidisciplinary team care.¹⁷⁻²¹ Sharing a common understanding of the goals agreed for each patient as strived for by the *weekly multidisciplinary team (MDT) ward round* is an example of how to give that cooperation a positive impetus.¹⁹ The aim of six interventions was to increase patient-centredness, or at least patient involvement.^{5,17-20,22-25} Tailoring nursing decisions to outcomes preferred by individual patients, which is the aim of the refined *Lorensen Scale*,²³ is an elaboration of this purpose.

The *nurse-led educative consultation*, described by Dedoncker et al.,²⁶ aims to improve disease management by patients. Nurse and patient summarize health education imparted during admission and anticipate health-related behaviour after discharge from the rehabilitation clinic.²⁶ Both Nir et al.²⁷ and Gual et al.²² focus on psychological and emotional aspects of rehabilitation. The *structured nursing intervention* does this through teaching coping strategies and preventing feelings of helplessness.²⁷ Huijben-Schoenmakers et al.²⁸ and Revello and Fields² both aim at increasing nursing involvement in rehabilitation. Revello and Fields’ intervention² does this, for example, through daily goal setting between patient and nurse. Interventions developed by Huijben-Schoenmakers et al.²⁸ and Yau et al.²¹ assist patients in adhering to their rehabilitation practice programme. The *home-based rehabilitation instruction (HRI)* sheet creates a condition for compliance by ensuring that patients understand the instructions.²¹

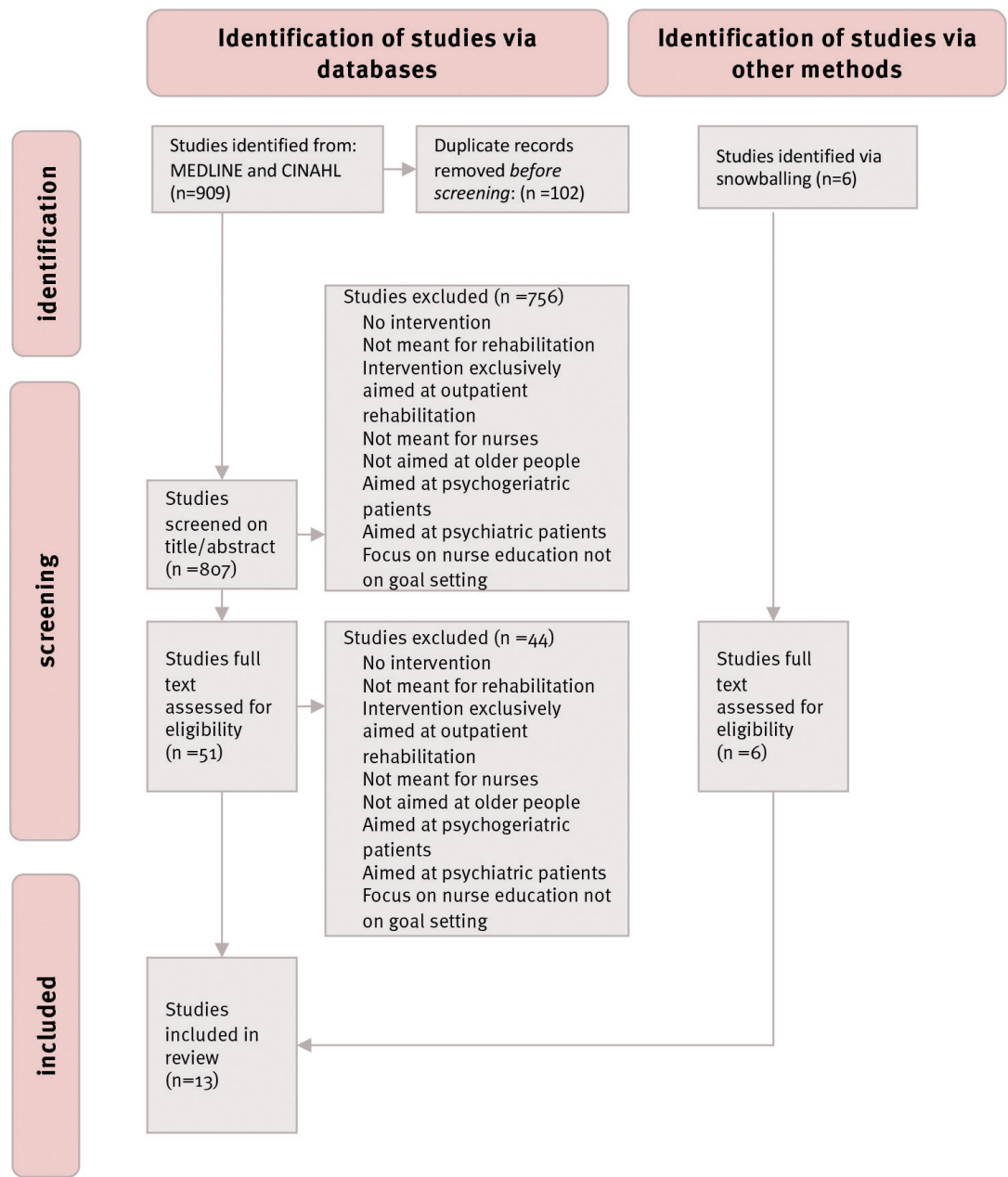


Figure 1. Flow chart of the search strategy.

3.2 | DESCRIPTIONS OF THE INTERVENTION AND ACCOMPANYING MATERIALS

Dedoncker et al.,²⁶ Nir et al.²⁷ and Yau et al.²¹ created interventions to support the patient to continue the rehabilitation at home, starting with an inpatient preparation. Using the *nurse-led educative and goal-setting consultation* the nurse, just before discharge from cardiac rehabilitation, rehearses lifestyle knowledge transferred in educational sessions with the patient and subsequently asks the patient to formulate lifestyle goals to work on at home.²⁶ This model uses a prevention information sheet consisting of two components: a reiteration part of cardiovascular risk factors and advice, and a box in which the patient is required to described his/her goals with regard to the acquired lifestyle style advice. The *structured nursing intervention* consists of 12 weekly sessions, starting in the Geriatric Rehabilitation Department and continuing at home after discharge, and is meant to enable discharged older patients to carry out their post-discharge rehabilitative treatment plan. A guidebook addressing common problems that arise after stroke, containing goals and a guide to achieving those goals, supports the intervention.²⁷ Yau et al.²¹ developed a protocol for the *home-based rehabilitation instruction sheet* development to help patients achieve goals after discharge.

Two interventions focus on the assessment of physical functioning.^{23,24} Ruland et al.²³ refined the *Lorensen's Self-Care Capability Scale*, a nursing instrument, comprising 13 dimensions of patient's self-care, to systematically assess patients' capability to care for themselves, with an extra step asking patients their opinion and collaborating with them in the goalsetting process. In the *collaborative functional goal setting*, patient and professional jointly set rehabilitation goals that can be assessed and evaluated by a standardized functional measurement instrument, either the Barthel Index or the Utrecht Scale for Evaluation of Rehabilitation.²⁴

Two interventions involve the nurse supporting the patient in achieving goals.^{2,28} Huijben-Schoenmakers et al.²⁸ developed an exercise workbook based on Clinical Nursing Rehabilitation Stroke Guidelines to support patients to work on their goals. The exercise book is often attached to the patient's wheelchair. In the *collaborative patient goal-setting initiative*, the nurse supports the patient in setting 1–2 goals he or she hopes to achieve in the following 24 hour period. The nurse writes the goals on the whiteboard in the patient's room.²

Two interventions provide a guidance path for goal setting and personalisation.^{5,22,25} The *motivational interviewing intervention* consists of four sessions of motivational interviewing, in which nurse and patient work collaboratively on a personalized rehabilitation plan complementing standard rehabilitation.²² The *increased participation model* described by Van De Weyer et al.²⁵ and Holliday et al.⁵ encompasses a workbook for the patient explaining the goal-setting process, a keyworker accompanying the patient in this process and team meetings with the patient present.

Table 1. Study Characteristics.

Author, year, country, The Objective of the name intervention ^a	Study	Research Method	Participants	Setting
Abrahamson et al. ¹⁷ 2017 USA <i>Patient-Oriented Interdisciplinary Sub-acute Care (POISe-Care)</i>	To evaluate the feasibility and impact of implementing a person-centered medical care model for post-acute care residents within a skilled nursing facility (SNF).	A mixed-method (qualitative and quantitative) pilot evaluation	Forty patients admitted for rehabilitation with a plan for community discharge, mean age 73 Four staff members (profession not specified)	An 89-bed Skilled Nursing Facility
Cai et al. ¹⁸ 2017 USA <i>Patient-Oriented Interdisciplinary Sub-acute Care (POISe-Care)</i>	To determine patients' capabilities of setting goals; to determine the clinical usefulness and practicality of those statements; to determine the priorities of post-acute patient perspectives; and to discuss the feasibility of goal-setting practice and its possible impact among post-acute patients.	Over a 6-month period, a total of 40 participants' care opinions were collected during 129 bedside care meetings in which patients were asked to explain their top three goals and top three concerns in their own words. A total of 129 valid POISe-Care meeting templates were reviewed.	Forty patients, 78% were between ages 65 and 100 Five patients had the secondary diagnosis: Dementia-related Behaviors. Residents with severe cognitive impairment as indicated by an initial cognitive screen—the Callahan 6-Item Cognitive Screen ¹¹ —were not included in the study.	An 89-bed Skilled Nursing Facility

Results Professionals	Results Patients	Author's reflections
Some time and planning constraints. Overall positive experience.	A significant ($P < .01$) improvement was noted between admission and discharge on the Care for Chronic Conditions scale and the Patient Activation Measure surveys. A trend toward improved satisfaction on the questions on whether the physician or nurse practitioner understands their needs ($P < .058$) and satisfaction with the physician or nurse practitioner ($P < .048$). Interviews revealed that the model encouraged an environment of respect and honesty in patient communication.	Streamlining care by focusing on patient priorities is an efficient means to deliver care. Current team care in skilled nursing facilities is organized around team routines rather than centering on the patient. Most nursing homes operate on relatively tight staffing margins and flat organizational structures that may hinder changing of routines. The facility had a leadership team, including a physician, that championed this change.
Does not apply.	The majority of patients were able to set goals and express concerns with the encouragement from the care team. Patients' goals were relatively consistent over time, while the patient concerns were more dynamic. Goals were clinically relevant and specific enough for use in guiding the care planning. The common goal 'Successful transition of care' demonstrated the importance of interdisciplinary care and the interdependence of social support with medical care needs.	Goal setting practice is influenced by appropriate reimbursement of care such as time to work individually with patients. Wider dissemination of the intervention may rely on access to advanced practice nurses to serve as team leaders. Patients' cognitive status could slow down the communicating process of goal setting. Patients who have little medical knowledge or have never thought about goals may find it difficult to set goals. The role switching between the medical professional and the patient is culturally unconventional. Evaluating patients' capacity to determine their rehabilitation pathway and the assistance they need from the care team are subject for further research.

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Table 1. Study Characteristics. *[continued]*

Author, year, country, name intervention ^a	The Objective of the Study	Research Method	Participants	Setting
Dedoncker et al. ²⁶ 2012 France <i>Nurse-led educative consultation setting Personalized tertiary prevention goals after cardiovascular rehabilitation</i>	To evaluate the perception and long-term effects of an educative consultation performed before cardiac rehabilitation discharge.	Patient interviews at 11 ± 1 months, and at 4.2 ± 0.2 years after discharge, to evaluate their satisfaction and assess cardiovascular risk factors (CVRF) control.	Fifty patients hospitalized following a coronary artery bypass, mean age 73 (standard deviation 8)	An inpatient cardiovascular rehabilitation program.
Gual et al. ²² 2020 Spain	To assess the impact of motivational interviewing, as a complement to standard geriatric rehabilitation, on functional improvement at 30 days after admission, compared to standard geriatric rehabilitation alone (study protocol).	Study protocol of a multicenter randomized clinical trial, with blinded outcome assessment	One hundred and thirty-six older (>=60 years) stroke survivors, according to protocol Excluded: Patients with severe post-stroke cognitive impairment (Pfeiffer SMPQ > 7 errors).	Geriatric rehabilitation units of three post-acute care hospitals.
Holliday et al. ⁵ 2007 UK <i>Increased participation</i>	To examine the impact of an increased participation goal-setting protocol in a neurorehabilitation setting.	An AB optimized balance block design with each block lasting 3 months, over an 18-month period.	Two hundred and one patients The patients in this study are typical of many patients seen by rehabilitation services. However, patients had relatively mild cognitive deficits which may not be applicable to all patients.	An inpatient neurological rehabilitation unit.

Results Professionals	Results Patients	Author's reflections
Does not apply.	A total of 90.2% of patients had better understanding of the risk factors and causes of their heart condition. 90.2% believed that it had enabled them to adopt a healthier lifestyle. 80.4% of the patients felt more responsible with regard to their heart condition and to the need to change their lifestyle. The consultation with a nurse was perceived as positive by 48.7% of the patients, compared with 4.87% who believed it would have been more appropriate to do it with a doctor; 46.3% had no opinion. Most long-term effects were better than usually reported in the field of multidisciplinary secondary prevention of CVRF.	Members of the rehabilitation team need to harmonize their educational approach. This harmonisation of information must be structured to ensure that it is implemented in contacts with patients.
Not applicable.	Not yet available.	This project is constructed from a 'triple aim' viewpoint: healthcare, efficiency and person-centered outcomes and experiences.
Does not apply.	Phase B patients ('increased participation') set fewer goals, of which significantly more were participation-related. These patients perceived the goals to be more relevant, and expressed greater autonomy and satisfaction with goal setting.	If we want patients and their family to contribute to planning the rehabilitation process, structures need to be developed that help them articulate ambitions.

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Table 1. Study Characteristics. *[continued]*

Author, year, country, name intervention^a	The Objective of the Study	Research Method	Participants	Setting
Van de Weyer et al. ²⁵ 2010 UK <i>Increased participation</i>	To explore rehabilitation professionals' perspectives about the use of two specific forms of goal setting used within the same setting; 'usual participation' and 'increased participation'.	A qualitative research approach: focus groups.	Fifteen rehabilitation professionals (speech and language therapist, occupational therapist, physiotherapist, nurse, doctor).	An inpatient neurological rehabilitation unit.
Huijben et al. ²⁸ 2013 The Netherlands <i>Prescribed exercises based on Stroke Guidelines in workbook</i>	To increase autonomous practice time of patients on the stroke unit of a nursing home.	An observational study. Practice time of older stroke patients was compared with the time observed in previous study in same setting using the Behavioral Mapping method.	Seventeen frail stroke patients, mean age of 75.8 (standard deviation 9) of whom 64% indicated to always have cognitive problems) and 17 subjects with the same characteristics who participated in previous observational study, of whom 94% indicated to always have cognitive problems).	Rehabilitation units of a nursing home.

Results Professionals	Results Patients	Author's reflections
Five themes were identified: the goal-setting tools; barriers to goal setting; the keyworker role; patient characteristics; and the nature of goals.	Does not apply.	Experiences of involving the patient in goal setting might positively change values within practice to accommodate the patient perspective. Staff turnover might prevent goal setting from being effective. Rotations and shift work are potential barriers to goal setting. Electronic patient records might solve this issue around team communication. Tightly budgeted therapy time provides too little room for goal setting. Goal setting in which patients' views are incorporated is a 'complex interactional activity'. Staff working in rehabilitation with specific groups of patients, such as those with stroke, or those with greater cognitive impairment, may have different experiences and views about goal setting. The implementation requires planning and preparation, with a requirement for staff education and support.
Does not apply.	Time spent on therapeutic activities increases significantly from 103.5 minutes to 156.5 minutes. Patients with more physical possibilities were more active during the day, resulting in a significant positive Barthel Index–therapy time relationship ($r = 0.73$, $P \leq 0.001$).	The exercise map made patients more aware of their own contribution to the rehabilitation process. The individual exercise map compelled the entire staff to be aware of patient's exercise goals. Nurses can have a more therapeutic role. This could solve the mismatch between recommended time for effective rehabilitation and actual exercise time. Therapists are not present in weekends and no therapy is provided. Nurses can fill this gap. Nursing home management should facilitate nurses to take this role in the multidisciplinary team in order to achieve a certain level of rehabilitation.

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Table 1. Study Characteristics. *[continued]*

Author, year, country, name intervention ^a	The Objective of the Study	Research Method	Participants	Setting
Monaghan et al. ¹⁹ 2005 UK <i>Weekly MDT ward round</i>	To determine the extent to which three forms of multidisciplinary team (MDT) care in stroke rehabilitation meet the standards set by the United Kingdom National Service Framework (NSF).	A consecutive assessment of 3 forms of care. Number of documented needs measured. Number of SMART goals measured. Patient and carer involvement measured by documented evidence. Team communication assessed with Team Climate Inventory. Questionnaire to estimate hours spent each week on the MDT round.	Three groups of 25 stroke inpatients, mean age 74.8; 72.6; 70.0 2 nurses 2 physiotherapists 2 occupational therapists	A stroke rehabilitation ward.
Nir et al. ²⁷ 2004 Israel	To examine the effect of a structured, comprehensive nursing intervention on the course of rehabilitation over the first 6 months after a first-ever stroke.	A quantitative research approach: FIM™ Instrument to measure patients' functional status Instrumental Activities of Daily Living Scale (IADL) Dietary Habits The stroke Self-Perception of Health Short Geriatric Depression Scale Internal-External Locus of Control Scale Rosenberg Self-Esteem Scale	155 stroke survivors (aged 57–93 years) and 140 carers	The geriatric rehabilitation department (GRD) of a university medical centre.
Revello & Fields ² 2015 USA <i>The SMART Goal evaluation method to help implement The collaborative patient goal-setting initiative</i>	A pre- and post-evaluation of an educational intervention.	Educational evaluation. Patient audits for adherence to obtaining patient daily goals.	40 nurses 63 patients	A mixed medical/surgical and rehabilitation unit (stroke, non-traumatic head injury, spinal cord injury).

Results Professionals	Results Patients	Author's reflections
The MDT ward round resulted in significantly ($p<0.001$), improved teamworking (team communication, understanding of team objectives and the roles of others in the team). The MDT ward round involved a significant increase in the time costs to each MDT member.	The most successful form of care in meeting the NSF guidelines was the MDT ward round in phase three. In comparison to the MDT meetings of phases one and two, there was - a significant improvement in the documentation of all patients' needs including medical and nutritional needs ($p<0.001$), - a significant increase in the number of SMART goals set for each patient ($p<0.013$), - and significantly more patients were involved in their rehabilitation ($p<0.001$), but still only 48%. - Very few carers were involved in any of the three phases.	Improvement of patient and carer involvement is an issue that needs further consideration. The MDT ward round does not achieve complete success. Not all patients have their objectives and goals agreed with them. It would be impossible to achieve this for all patients due to difficulties in communication and cognition that are common after stroke, however, a 50% rate is not satisfactory.
Does not apply.	The early effects of the nursing intervention were on functional status (FIM instrument), health behavioral changes (eating habits) and depression, whereas changes in self-perception of health and self-esteem took place 3 months later, after the completion of the intervention program, possibly indicating an accumulation effect for these variables.	The involvement of the caregiver in the intervention provided important support to the patient and made the caregiver an equal partner in achieving the intervention's goal.
Results of nurse adherence in writing SMART collaborative goals increased from 11% pre-education to 63% post-education.	Results of the patient audits demonstrated that: 63% of the patients had their goals written on their whiteboard (compared to 11% pre-education), 67% could articulate their goals (compared to 37% pre-education), 67% said their nurse collaborated with them on their goals (compared to 20% pre-education), and 91% said they felt well informed by their nurses and physician (compared to 57% pre-education).	Changing healthcare practice is a complex process that takes months or even years. The unit's educator has become a change agent for increasing adherence with the patient daily goals initiative. Routinely auditing and sharing the results of the audits with the nurses will help sustain the initiative. Education alone may not be sufficient to sustain adherence; it should be combined with follow-up support.

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Table 1. Study Characteristics. *[continued]*

Author, year, country, The Objective of the name intervention^a	Study	Research Method	Participants	Setting
Ruland et al. ²³ 1997 USA <i>Lorensen's Self-Care Capability Scale (refined)</i>	To test a decision-analytic approach as a strategy for formalizing subjective judgement, which makes it possible to include patients' own values and preferences in planning patient care.	Patient interviews. Healthy adults filled in assessment and provided feedback in a group discussion. Nurse interview.	Four Patients (71–73 years) Eight healthy older adults participating in a Tai-Chi class One clinical nurse specialist	A 15-bed medical unit for acute care for older people.
Smit et al. ²⁴ 2017 The Netherlands <i>Collaborative functional goal setting (CFGs)</i>	To explore the feasibility of collaborative functional goal setting (CFGs), i.e. using standardized functional measures to set and evaluate functional goals during geriatric rehabilitation.	Open in-depth interviews with both the patients and professionals working with the intervention were conducted and qualitatively analysed.	A nurse practitioner and two physicians. Five geriatric stroke rehabilitation patients (age 73–87 years). The research was specifically focused on geriatric stroke rehabilitation patients because they wished to test the intervention in patients with a high incidence of cognitive and communicative problems.	Two geriatric rehabilitation wards.

Results Professionals	Results Patients	Author's reflections
Nurse: Tool helpful to get to know preferences, values and perceptions: helpful in clarifying the goals. Tool helpful to get to know strengths and weaknesses in functioning independently. Use of instrument increases patients' awareness and motivation to regain self-care functioning. Patients self-report of their ability to perform ADL might not be optimal in hospital: better perform a pre-hospital visit.	Patients: Tool helpful in clarifying goals. It provided important information about their ability to perform independently and to create a shared understanding between nurse and patient. Tool was helpful in making the nurse better understand what was important to them. Shared approach provides an opportunity for increased communication and clarification between patients and nurse. Healthy older adults: important to be highly involved in deciding what is important. Care should be planned based on their needs. Help is needed to determine what is main concern. Instrument somewhat detailed and lengthy.	-
Relevance of patient-centered goal setting is emphasized. CFGs regarded as potentially helpful in facilitating the goal-setting process. Use of functional instrument considered particularly supportive in setting and evaluating rehabilitation goals. Professionals experienced several implementation difficulties.	According to the patients the professionals set the goals. A plan was either not presented or the content of the plan was not clear. Patients desired to be involved in the goal-setting process. Wishes about the extent of involvement varied.	Goal setting is generally new to patients therefore they might have difficulty understanding what is expected of them. The entire multidisciplinary team needs to be trained in the intervention to ensure a uniform and multidisciplinary approach. The training must be regularly updated so it becomes a familiar daily routine. Sufficient time and resources must be made available for the implementation of the intervention.

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Table 1. Study Characteristics. *[continued]*

Author, year, country, The Objective of the name intervention ^a	Study	Research Method	Participants	Setting
Yau et al. ²¹ 2002 Hong Kong <i>Outcome-focused nursing practice</i>	To examine the effect of an outcome-focused nursing practice on goal achievement.	A quantitative research approach: evaluation of functional performance.	Twelve patients Mean age 70.1	Medical & geriatric rehabilitation center.

^aEntries in this table are mainly in alphabetical order of author. However, entries describing the same intervention are listed directly below each other.

Table 2. Interventions Characteristics.

Author(s), year, country, name intervention	Intervention goal	Intervention description
Abrahamson et al. ¹⁷ 2017 Cai et al. ¹⁸ 2017 USA <i>Patient-Oriented Interdisciplinary Sub-acute Care (POISE-Care)</i>	Patient- centeredness. Team development.	1. bi-weekly interdisciplinary care plan meetings, scheduled at time of patient's preference and held in patient's room; 2. patient selection of health-related goals; 3. use of lay language; 4. team accountability to the patient for patient care preferences; 5. monthly care team meetings on team's performance.
Dedoncker et al. ²⁶ 2012 France <i>Nurse-led educative consultation setting, Personalized tertiary prevention goals after cardiovascular rehabilitation</i>	Tertiary prevention: improve management of disease by patient after cardiac events.	Final consultation with nurse at end of cardiovascular rehabilitation program in which patient and nurse summarize the information provided during the stay. Patients set goals to control their CVRF.

Results Professionals	Results Patients	Author's reflections
Does not apply.	Ten patients were able to achieve or exceed the standards of their individualized therapeutic goals.	The home-based rehabilitation instruction (HRI) sheet meant for patients, also improves communication within the rehabilitation team. Formulating goals requires time for discussion and negotiation of all involved disciplines. An outcome focused approach helps to realize the effectiveness of a approach. Nurses can play an important role to empower patients as well as members of the rehabilitation team.

Accompanying materials for patients or professionals	Nursing role in intervention
On admission, patient receives information about the model with details of his or her own role in the success of his or her care. Patient receives a 'CEO Report' (information from the meeting to refresh memory or share with family). A structured communication guide for team members to ensure that bedside meetings cover all of the necessary components and that each team member is given an opportunity to provide input within their area of expertise. Two whiteboards in the practitioner office to help team members review meetings and remaining tasks related to the action items resulting from these meetings.	Nurse is one of the multidisciplinary team members. Specific deployment of the nurse is not discussed.
Information sheet used to assess patient's understanding of their condition and to establish a program with goals for the future. Copy of the information sheet is sent to the patient's general practitioner (GP), to obtain long-term involvement. Copy is given to the patient.	Summarize the information provided during the stay. Check whether patients are aware of their individual problems to be addressed to diminish their health risk.

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Table 2. Interventions Characteristics. [continued]

Author(s), year, country, name intervention	Intervention goal	Intervention description
Gual et al. ²² 2020 Spain <i>Motivational Interviewing (MI) intervention</i>	To empower, motivate and engage the person in planning and participating in the rehabilitation plan	Four sessions of motivational interviewing by nurses: 1. Engage the stroke survivor in his/her care. 2. Collaborative co-creation of a personalized rehabilitation plan, complementing the routine geriatric rehabilitation. 3. Reinforce engagement and adherence to the plan to maintain behavior change and functional improvement at 3 months.
Holliday et al. ⁵ 2007 Van de Weyer et al. ²⁵ 2010 UK <i>Increased Participation</i>	Involving patients in goal setting.	Prior to admission: patient given 3-stage workbook that explains goal-setting process in detail. Day of admission key worker (assigned to every patient) interview focused on patient experience to facilitate advocate role within goal setting. Week of admission key worker works with patient to complete workbook. Friday of admission week goals set by therapists and patient working together. Patient present in goalsetting meetings.
Huijben et al. ²⁸ 2013 The Netherlands <i>Map with prescribed exercises based on Stroke Guidelines</i>	Increase practice time of patients through nursing involvement.	Each week exercises based on 4 interventions from the Clinical Nursing Rehabilitation Stroke Guidelines are adapted to individual goals, interests and rehabilitation level of the patient.
Monaghan et al. ¹⁹ 2005 UK <i>Weekly MDT ward round</i>	Improve multidisciplinary team (MDT) care for stroke patients By meeting UK National Service Framework standards: 1. Clearly documenting plans. 2. Involve patients and carers. 3. All professionals share common understanding of goals agreed for each patient.	Weekly MDT ward round at the foot of each patient's bed using a form to enhance documentation of patients' needs (self-care, bowel, urine, cognition, communication, mood, nutrition and medical problems), their goals and their involvement with rehabilitation. Patients' relatives and/or carers were invited to attend.

Accompanying materials for patients or professionals	Nursing role in intervention
Personalized rehabilitation plan agreed between stroke survivors and nurses based on stroke survivor's goals, needs, preferences and capabilities.	Creating engagement with the stroke survivor by exploring his/her preferences, values and goals, as well as his/ her knowledge and expectations about stroke rehabilitation and recovery. Enhancing motivation by evoking strengths and abilities. Follow-up and reinforcement. Adapting the plan to the improved abilities and to home setting. Debriefing with other disciplines.
Patient workbook in three sections: 1. prioritize activity and participation domains 2. identify specific tasks within those domains they wish to work on 3. determining goals to achieve within time frame of rehabilitation admission.	Support patients working through goal setting workbook. Be patients' advocate in multidisciplinary team meeting.
Exercises are documented in exercise map mostly fixed to wheelchair of patient.	Adapt exercises to the individual goals, interests and rehabilitation level of the patient with physiotherapists and occupational therapists. Exercise with the patient. Encourage patients to follow exercise regime closely. Coordinate and facilitate the exercises within the daily activities and care of the patient. Inform the multidisciplinary team about the individual progress. Update exercise map weekly according to the needs of the patient.
Form for team members to enhance documentation of patients' needs, goals and involvement with their rehabilitation. The form lists all potential problems so that relevant problems can be circled, alongside whether the problem has changed. The form has prompts to note whether patients and their carers were involved in their therapy, alongside prompts for goals to be set and monitored.	Nurse is one of the MDT-members. Specific deployment of the nurse is not discussed.

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Table 2. Interventions Characteristics. [continued]

Author(s), year, country, name intervention	Intervention goal	Intervention description
Nir et al. ²⁷ 2004 Israel <i>Structured nursing intervention</i>	To improve the physical, psychological and emotional rehabilitation during the first 6 months after stroke through a structured, comprehensive nursing intervention added to routine rehabilitation.	The student nurse meets with the patient and carers once a week, for 12 consecutive weekly sessions of 1–2 hours each. Beginning in the first week after admission to the Geriatric Rehabilitation Department and continues at home after discharge. The nursing intervention focuses on the affective, cognitive and instrumental domains. Affective domain: creating an atmosphere of mutual trust between the patient, the carer and the student nurse. Cognitive domain: the patient's perception of illness, and understanding of the rehabilitation process. Instrumental domain: increasing the patient's self-care skills for accepting responsibility for his or her own health status.
Revello & Fields 2015 ² USA <i>The Collaborative Patient Goal-Setting Initiative</i>	Better patient outcomes through nurse and patient collaborative goal setting.	1. Each day the nurse supports patient setting 1–2 goals he or she hopes to achieve in the following 24-hour period. The goals were to be realistic and achievable. 2. The following evening, if one or both of the goals were not met, the patient could opt to continue the previous goals or develop new ones. 3. The patient's nurses on other shifts and any therapists working with the patient acknowledged the goals with the patient and made an effort to see that the goals were met. This procedure continued until the patient was discharged.
Ruland et al. ²³ 1997 USA <i>Lorensen's Self-Care Capability Scale (refined)</i>	Tailoring nursing-care decisions to desired outcomes as preferred by individual patients.	1. Patient is asked to name areas that he/she perceives as the predominant problems and to indicate which are most important to address. 2. Nurse and patient assess performance on each self-care function with the help of <i>Lorensen's Self-Care Capability Scale LSCS</i> 3. Together select desired level of functioning and evaluate progress.

Accompanying materials for patients or professionals	Nursing role in intervention
A guidebook based on Orem's model of self-care containing topics that address common problems that arise after stroke. Each topic contained goals, a guide to achieving those goals and a feedback form. The feedback form was used to evaluate the extent to which the aims of the meeting were achieved.	Open channels of honest and sensitive communication. Provide information and knowledge of the disease. Teach coping strategies. Give practical tools that allow older persons to solve problems. Prevent feelings of helplessness. Together with each patient set goals that are both meaningful and realistic. Be present after discharge from hospital and involve carer.
Whiteboards in patients' rooms. A written guideline of the initiative is available on the hospital intranet.	Set SMART goals with patients. Determine whether necessary resources are available to meet goals. Evaluate goal achievement with patients.
The Lorensens Self-Care Capability Scale (LSCS) comprises 13 dimensions of patient's self-care abilities.	Assess patients' strengths and weaknesses in functioning independently. Elicit patients' preferences. Help patients make informed decisions. Involve patients in planning their care. Evaluate progress together with patients.

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Table 2. Interventions Characteristics. [continued]

Author(s), year, country, name intervention	Intervention goal	Intervention description
Smit et al. ²⁴ 2018 The Netherlands <i>Collaborative Functional Goal Setting (CFGGS)</i>	Facilitate the process of jointly setting goals by the use of a measurement instrument.	1. On admission, nurse completes Barthel Index (BI) or functional items of the Utrecht Scale for Evaluation of Rehabilitation (FUSER). 2. Test scores are presented in multidisciplinary meeting (MDM). 3. Multidisciplinary team set functional goals. Goals are presented as target scores by physician / nurse practitioner. 4. Goal-setting meeting with patient and physician / nurse practitioner. Patient is invited to set their own functional goals. 5. Shared decision-making in defining the patient's goal between patient and physician. 6. Prior to every 2 weekly MDM, new functional assessment is conducted by nurse. 7. During MDM the functional goals and assessment target scores will be reviewed. 8. Physician / nurse practitioner inform patient about the outcome of MDM. 9. Patient can be discharged when goals are met.
Yau et al. ²¹ 2002 Hong Kong <i>Outcome-focused nursing practice</i>	To facilitate the multidisciplinary team in delivering interventions in an integrated manner. To help patients achieve goals after discharge.	A pre-discharge planning program to enable discharged older patients to carry out their post-discharge rehabilitative treatment plan effectively and to achieve their treatment goals in their home environment.

Finally, the *Patient-Oriented Interdisciplinary Sub-acute Care (POISe-Care) model*^{17,18} and the *weekly MDT ward round*¹⁹ concern interdisciplinary team care meetings with the patient present and invited to express their goals.

3.3 | THE NURSING ROLE

The 11 interventions appeal to different aspects of the nursing profession: assessing self-care skills, setting goals with the patient, linking the needs of the patient with multidisciplinary professional treatment and vice versa and thus playing an intermediate role and supporting goal achievement. In the *collaborative functional goal setting*, the nurse assesses patients' functional status and shares the scores in the multidisciplinary team meeting.²⁴ With the help of the refined *Lorensen's Self-Care Capability Scale*, the nurse assesses the self-care skills together with the patient. In

Accompanying materials for patients or professionals	Nursing role in intervention
Two standardized functional measurement instruments: the Barthel Index and the Utrecht Scale for Evaluation of Rehabilitation.	Nurse assesses patients' functional performance with BI or functional items of the fUSER and presents results in MDM, prior to setting goals in MDM.
Protocol for home-based rehabilitation instruction (HRI) sheet development: instruction on how to make a home-based instruction sheet in layman terms.	Nurses facilitate joint work towards the HRI. Nurses consolidate rehabilitation programs advanced by each team member. Nurses assess the ability of the older patient in understanding and performing the prescribed regimen. Nurses facilitate the transforming of requirements into achievable goals as perceived by patients and carers. As case manager, nurses maintain telephone contact after discharge to facilitate compliance.

the case of the nurse and patient disagreeing about the importance of a certain self-care function or the desired outcome, the nurse helps the patient make an informed decision.²³ Setting goals with the patient is part of five interventions.^{2,5,22,23,25-27} A specific aspect of the *collaborative patient goal-setting initiative* is helping patients to make goals realistic and achievable.² Linking the needs of the patient with multidisciplinary professional treatment and vice versa, is a role the nurse has in at least five interventions. In Huijben-Schoenmakers' intervention, the nurse consults physiotherapists and occupational therapists to adjust the exercises to the preferences of the patient.²⁸ In the *motivational interviewing (MI) intervention*,²² the nurse debriefs with the rehabilitation team pre- and post- each MI session, to tailor and adjust the rehabilitation plan. In the increased participation intervention, the nurse, as one of the possible keyworkers, is the patient's advocate during the goal-setting meetings:

‘the keyworker helps to understand and articulate the patient’s aspirations at this meeting’.^{25(p1425)} Through the *nurse-led educative and goal-setting consultation*, the nurse harmonizes the information given by different professionals.²⁶ In the *outcome-focused nursing practice*, nurses unify the rehabilitation programs of the different team members into the *home-based rehabilitation instruction sheet*.²¹

Through planning and scheduling on the one hand and emotional support on the other, the nurse aims to support goal achievement in at least six interventions. Supported by the exercise book, the nurse in Huijben-Schoenmakers’ intervention coordinates and facilitates the exercises within the daily activities and care of the patient, exercises with the patient and encourages each patient to follow their exercise regime closely and exercise autonomously.²⁸ In the *collaborative patient goal-setting initiative*,² the nurse aims to support goal achievement by each evening writing the goals on the whiteboard in the room, sharing them with colleagues through reports and as a team making an effort to see that the goals are met by, for example, ensuring necessary resources are available to meet goals.

The three-pronged approach of the *increased participation* intervention (i.e. goal-setting workbook, assigned keyworker and presence of the patient in the goal-setting meetings) resulted, among others, in short-term goals as ‘stepping stones’, reset on two- or three weekly cycles⁵, thus clarifying the path towards the long-term goal. In the *outcome-focused nursing practice*, nurses assess the ability of the older patient in understanding and performing the prescribed regimen and transforms requirements into achievable goals as perceived by patients and carers using lay language.²¹ In the *structured nursing intervention*, the nurse provides psychosocial and emotional support to patient and carer.²⁷ This is also the case in the *motivational interviewing intervention* in which the nurse strives to enhance motivation by evoking strengths and abilities.²²

Abrahamson et al.,¹⁷ Cai et al.¹⁸ and Monaghan et al.¹⁹ do not address the specific duties of the nurse on the team. In the *POISe-Care model*, the entire team, including the nurse, is focused on making the rehabilitation process as insightful as possible for the patient.¹⁷

3.4 | IMPACT OF THE INTERVENTIONS

Table 1 presents the results of the included studies. In this section, we pay attention to the described impact of the interventions as well as the author’s reflections (Table 1). We list four: patient awareness of the rehabilitation process; patient ownership; required skills; and time, money and implementation issues.

3.4.1 | PATIENT AWARENESS OF THE REHABILITATION PROCESS

Research on four interventions reports benefits in terms of mutual understanding and as a possible effect of mutual understanding: increased patient awareness of the

rehabilitation process (See Table 1).^{2,23,26,28} The *nurse-led educative and goal-setting consultation* resulted in a majority of the participating patients better understanding risk factors and feeling more responsible for their progress.²⁶ The *collaborative goal-setting initiative* led to a growing number of patients that could articulate their goals and felt well informed.² Huijben-Schoenmakers' workbook led to more time spent on therapeutic activities, including autonomous time.²⁸

3.4.2 | PATIENT OWNERSHIP

Keyworkers using the *increased participation intervention* experience a transfer of ownership of treatment goals from the team to the patient, and some also linked this to increased motivation. The workbook used in this intervention played a role in supporting the patient to create individual, more context-based, goals.²⁵ Abrahamson et al.^{17(p542)} describe similar positive impressions of the *POISE-Care model*: 'it empowers our residents to own what is going on and to want more'. The majority of the *increased participation group* of patients reported that they choose their own goals, whereas patients of the 'usual practice' group mostly reported that the professionals asked them to agree to team-formulated goals.^{5(p579)} Patients in Smits' study reported that professionals mainly set the goals.²⁴ A plan was either not presented to them or the content of the plan was not clear. Patients expressed a desire to be involved in the goal-setting process, but their wishes about the extent of involvement varied.²⁴

3.4.3 | REQUIRED SKILLS

With regard to professional skills, some keyworkers working with the *increased participation intervention* experienced a lack of expertise within the area of mobility as a barrier to the identification of appropriate goals. Furthermore, nurses experienced that a number of patient characteristics had an impact on both their role and the goal setting.^{18,24,25} Van De Weyer et al.²⁵ therefore suggest that education is needed in the complex interactional skills required to manage patient-focused goal setting. Nurses who perform the *motivational interviewing method*²² received training in motivational interviewing and nurses who perform the *structured nursing intervention*²⁷ received instruction in rehabilitative geriatric care, communication and family care.

3.4.4 | TIME AND IMPLEMENTATION ISSUES

As it comes to barriers to work with an intervention time was mentioned four times.^{17,19,21,25} Some professionals experience goal setting as a time-intensive process that comes at the expense of rehabilitation itself.^{17,25} This can be especially the case when therapy time is tightly budgeted.^{17,18,24,25} Van De Weyer et al.²⁵ also mention problems with continuity, linked to shiftwork. Factors that promote implementation are, among others, advanced practice nurses as team leader,¹⁸ education and support by, for example, a unit educator² and nursing home management facilitating nurses to take their role in the multidisciplinary team.²⁸

4 | DISCUSSION

The aim of this study was to explore the range of interventions on goal setting and achieving available to nurses in geriatric rehabilitation, and to describe their distinctive features. Such interventions might strengthen the interpretive and integrative roles of the rehabilitation nursing profession as described by Kirkevold⁶ and as a result may support patients in playing an active role in their rehabilitation process.

We could only identify 11 interventions, of which seven were explicitly meant for nurses. However, this scoping review identified useful elements regarding the nursing contributing to patient-centredness and team collaboration—both important features when striving for quality of care in today’s rehabilitation.^{29,30} This study has uncovered several important research and educational topics concerning the nursing role and required skills when it comes to working with goals.

The first remarkable finding is that the *structured nursing intervention*²⁷ is the only intervention that has family involvement as a key component. Other interventions allow for family involvement, but always linked to the involvement of the patient. Loft et al.³¹ emphasizes the importance of involving relatives for two reasons: first, patients want to discuss what is going on together with their family; and second, they need help keeping track of all the information given. Galvin et al.³² found that increased family involvement reduced carer strain and facilitated transition to the home setting. Kirkevold⁶ explains that the integrative function also entails assisting people who survived a stroke back into their lives by helping them and their relatives plan for their future situation. The vital role of family should be incorporated in interventions and the skills involved in working with them need to be part of nursing education.

The second remarkable finding is that only two interventions, the *collaborative functional goal setting*²⁴ and the refined *Lorensen’s Self-Care Capability Scale*²³ focus specifically on the nurse’s role in assessing patients’ abilities. An assessment could help to understand the problems experienced by the patient and possibly support the joint formulation of goals. Some keyworkers working with the *increased participation intervention* experience a lack of expertise within the area of mobility as a barrier to the identification of appropriate goals. As Van De Weyer et al.²⁵ suggest, it might be more feasible to let the keyworker take on the role of patient advocate in the goal-setting process, instead of having the nurses set appropriate goals by themselves. It is precisely this integrating and interpreting role that is paramount and well reflected in most other interventions, although shaped in many different ways. For example, both the *nurse-led educative consultation*²⁶ and the *home-based rehabilitation instruction sheet*²¹ declutter the multiple messages from the separate allied health professionals and help the patient translate them to (home) goals. However, Dedoncker et al.²⁶ does this via an educational session while in Yau’s intervention,²¹ the nurse writes an aggregated

instruction. We tend to conclude that there are multiple ways at several moments during the rehabilitation process for the nursing profession to support patient's in working on their goals, there might not be a preferred intervention. More important for the nurse is to be aware of this central role and of the available interventions. Education about these multiple ways and corresponding interventions will support nurses in mastering this role. Two educational programmes demonstrate the effectiveness of this multifaceted approach, namely *Rehabilitation 24/7*³³ and the *SMART Goal Evaluation Method*.² Both interventions focus on strengthening the nursing staff possibilities to incorporate rehabilitation practices into their daily routine through, among others, working systematically with patients' goals. Target behaviours of the *Rehabilitation 24/7* course³³ are: talking with and involving patients systematically in the goals every day and every shift; documenting process and progress in the medical record; making sure always to know the patient's goals—long term and short term—before starting the care session; using lay language to tell patients' relatives what they are doing in the rehabilitation³⁴. The *SMART Goal Evaluation Method*² is aimed at writing SMART goals and collaborating with patients to achieve them. Both educational programmes show positive results: nursing staff experience increased focus on their role and functions in rehabilitation practice³³ and patients feel better informed and experience that the nurse collaborates with them.²

A third finding is the difference between interventions in the way they strive for patient involvement. Some interventions let the patient take the lead in identifying problem areas to ensure that the goals that arise from the problems are individually tailored.^{23,25} Other interventions work from problem lists that professionals have drawn up.¹⁹ The *POiSe-Care intervention*¹⁷ goals are drawn up by professionals and health related but made relevant through the use of lay language. The goals set in the *collaborative patient goal-setting initiative* are said to be informal and not part of patients' medical records, and thus are more patient-centered, but they seem largely health related (e.g. having a soft stool within 1h of suppository given; will administer my own insulin injection^{2(p322)}) and patients receiving the *motivational interviewing intervention*²² follow a standard rehabilitation programme but with personal goals added. Goals need to be meaningful.⁴ If patients are unable to see their relevance, the rehabilitation goals identified by the professionals may lose their meaning and subsequently their motivational power.⁶ Multiple studies have included participants with cognitive problems.^{5,18,22,24,28} Further research among professionals could clarify the reasons for using prescribed goals. Are they being used because of the sometimes limited cognitive abilities of older people to set their own goals or to ensure that the patient's goals fit within the rehabilitation professional's possibilities? Further research is also required to investigate through interviews with patients in geriatric rehabilitation the content and language of 'relevant' goals. This could clarify if the nursing role is to help patients formulate their own goals or to translate professional goals into patient's language or world of experience.

Similar to the admission phase, the nature of patient-input seems to differ in the actual rehabilitation phase. The nurse, in consultation with the physiotherapist and occupational therapist, adapts Huijben-Schoenmakers' exercises.²⁸ Patients do not seem to be actively involved. In the *POISe-Care model* 'the interdisciplinary team was accountable to report on progress made toward patient goals and care preferences, and patients received a document entitled the "CEO Report"'.^{17(p540)} Although we endorse the importance of keeping patients informed and helping them refresh their memory, the words 'accountable' and 'CEO Report' somehow create an impression of a passive patient waiting for rehabilitation. This highlights the complexity of the phenomenon of patient participation in geriatric rehabilitation. A full picture of the extent to which we expect older people to be able to exhibit self-regulating behaviour in a professional-dominated setting or whether they need ongoing support in doing so, is lacking. This should be the subject of further research.

Not only does the nature of the intervention influence the way patients are involved, but the characteristics of the patient themselves might also play a role. Keyworkers in the *increased participation model* experienced that not all patients are equally competent in participating in the process of formulating their goals—for example, patients with a sudden onset of an illness.²⁵ This is confirmed by Thompson's³⁵ framework of patient participation. This shows that for patients in an acute phase of their disease, or with less knowledge and confidence or a strong trust in medicine, it can be difficult to actively participate. When it comes to required skills, Van De Weyer et al.²⁵ mention the ability to work together with a variety of patients with different needs as a key attribute for rehabilitation. Our recommendation is to make these complex interactional skills subject of nursing education, how to stay away from patronizing and taking over but at the same time be aware of and act on patients' need for support.

All interventions were investigated in research, and studies examining the experiences of professionals reveal another important indicator regarding the skills required. Some professionals experience goal setting as a time-intensive process, not as an essential prerequisite and part of the treatment.^{17,25} Educational programmes like *Rehabilitation 24/7*³³ and the *SMART Goal Evaluation Method*² seem necessary to overcome this misunderstanding. Through the training, nurses come to realize that working on goal setting and patient involvement may require an investment of time, but could lead to important improvements in patients' outcome.³³ Ideally, training should go hand in hand with implementing interventions that are patient-oriented. The strength of the combination is shown by the following statement from a keyworker in the *increased participation intervention*²⁵. Attending a goal-setting meeting with patients being present proved a challenge. On the other hand, changing back from *increased participation* to *usual participation* (i.e. patient not present) for some felt inappropriate: '...it almost became rude not to have the patient present. It actually felt like we were making our own assumptions about their status, rather than having them involved'.^{25(p1423)}

5 | LIMITATIONS

This scoping review has some limitations. First, we only included studies from research databases and did not access databases providing grey literature. Second, we did not perform the second step of the intervention component analysis¹⁶ because interventions differed too much to compare outcomes based on characteristics. Third, we cannot state conclusions about the effectiveness of the interventions because we did not assess or exclude articles based on their research quality. Finally, most of the articles included lacked a comprehensive description of the intervention. We did reach out to the authors and in some cases received additional information; however, it is possible that our overview of means and materials and the role of nursing is incomplete.

6 | CONCLUSION

The greater aim of this scoping review was to advance the field of geriatric rehabilitation by contributing to a clearer role for nurses in that field. The diversity of the found interventions demonstrates the many opportunities the nurse has for playing an intermediate role between the patient and the multidisciplinary team. With the support of nurses, increased patient awareness of the geriatric rehabilitation process and transfer of ownership of treatment goals from the multidisciplinary team to the patient might be achieved. The nursing profession should be aware of this central role. Nurses working in geriatric rehabilitation might require additional training in goal setting and achieving. This should go hand in hand with implementing interventions.

IMPLICATIONS FOR PRACTICE

WHAT DOES THIS RESEARCH ADD TO EXISTING KNOWLEDGE IN GERONTOLOGY?

- This overview of interventions on working with goals in geriatric rehabilitation helps to provide a more accurate picture of nurses' ability to support patients in working on goals.
- The diversity of the found interventions demonstrates the many opportunities the nurse has, for playing an intermediate role between the patient and the multidisciplinary team.
- With the support of nurses, increased patient awareness of the geriatric rehabilitation process and transfer of ownership of treatment goals from the multidisciplinary team to the patient might be achieved.

WHAT ARE THE IMPLICATIONS OF THIS NEW KNOWLEDGE FOR NURSING CARE WITH OLDER PEOPLE?

- This review supports the field of geriatric rehabilitation in working on a clearer role for nurses. Education about this role and the available interventions will raise awareness of this role.
- Some professionals experience goal setting as a time-intensive process, not as an essential prerequisite. Education and at the same time implementing nursing interventions might contribute to overcoming this barrier.

HOW COULD THE FINDINGS BE USED TO INFLUENCE POLICY OR PRACTICE OR RESEARCH OR EDUCATION?

- This scoping review provides leaders in nursing care and nursing education for older people with practical information.
- A full picture of the extent to which we expect older people to exhibit self-regulating behaviour in a professional dominated setting is lacking. Future research on this topic is needed.
- Interactional skills on patient participation need to be subject of nursing education: learning how to stay away from patronizing and taking over, but at the same time, be aware of and act on patients' need for support.

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APPENDIX 1

FULL SEARCH STRATEGIES PER DATABASE

Search strategy for Ebsco/CINAHL (4 August 2021)

#	Query	Results
S6	S1 AND S2 AND S3 AND S4 AND S5	220
S5	MH "Goals and Objectives+" OR TI("goal" OR "goals" OR "action plan*") OR AB("goal" OR "goals" OR "action plan*") OR KW("goal" OR "goals" OR "action plan*")	154,927
S4	MH "Practice Guidelines" OR MH "Education+" OR MH "Curriculum+" OR MH "Education, Clinical+" OR MH "Academic Performance+" OR MH "Educational Measurement+" OR MH "Knowledge+" OR MH "Professional Knowledge+" OR MH "Learning Environment" OR MH "Learning Environment, Clinical" OR MH "Learning Methods+" OR MH "Program Development+" OR MH "Students, Pre-Nursing" OR MH "Students, Undergraduate" OR MH "Students, Nursing, Graduate+" OR MH "Students, Graduate+" OR MH "Teaching Methods+" OR MH "Teaching Materials+" OR MH "Patient Education+" OR MH "Patient Education (Iowa NIC)+" OR MH "Mentorship" OR MH "Nursing Care Plans+" OR MH "Nursing Protocols+" OR MH "Protocols+" OR MH "Patient Centered Care" OR MH "Consumer Participation" OR MH "Practice Patterns" OR MH "Motivation" OR MH "Hospitals+/ED" OR TI("intervention*" OR "method" OR "methods" OR "guide*" OR "guidance*" OR "education*" OR "coach*" OR "project*" OR "practice*" OR "protocol*" OR "standard*" OR "instrument*" OR "framework*" OR "model" OR "models" OR "mentor*" OR "task oriented train*" OR "canadian occupational performance measure*" OR "copm" OR "goal attainment scal*" OR "patient involvement*" OR "patient empowerment*" OR "patient activation*" OR "patient engagement*" OR "patient cent*" OR ("patient*" N5 (collaborati*" OR "directed" OR "led therap*" OR "regulated")) OR "motivation*" OR AB("intervention*" OR "method" OR "methods" OR "guide*" OR "guidance*" OR "education*" OR "coach*" OR "project*" OR "practice*" OR "protocol*" OR "standard*" OR "instrument*" OR "framework*" OR "model" OR "models" OR "mentor*" OR "task oriented train*" OR "canadian occupational performance measure*" OR "copm" OR "goal attainment scal*" OR "patient involvement*" OR "patient empowerment*" OR "patient activation*" OR "patient engagement*" OR "patient cent*" OR ("patient*" N5 (collaborati*" OR "directed" OR "led therap*" OR "regulated")) OR "motivation*" OR KW("intervention*" OR "method" OR "methods" OR "guide*" OR "guidance*" OR "education*" OR "coach*" OR "project*" OR "practice*" OR "protocol*" OR "standard*" OR "instrument*" OR "framework*" OR "model" OR "models" OR "mentor*" OR "task oriented train*" OR "canadian occupational performance measure*" OR "copm" OR "goal attainment scal*" OR "patient involvement*" OR "patient empowerment*" OR "patient activation*" OR "patient engagement*" OR "patient cent*" OR ("patient*" N5 (collaborati*" OR "directed" OR "led therap*" OR "regulated")) OR "motivation*"	3,719,521

[continued on next page]

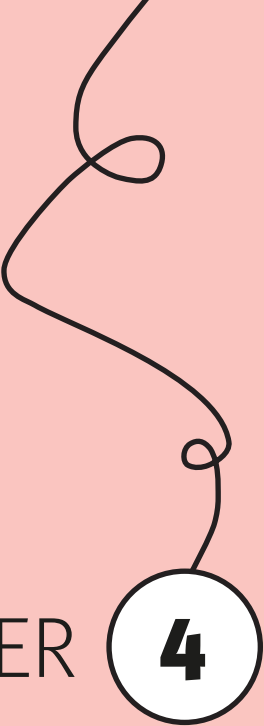
Search strategy for Ebsco/CINAHL (4 August 2021) [continued]

#	Query	Results
S3	MH "Rehabilitation" OR MH "Occupational Therapy" OR MH "Physical Therapy" OR MH "Hand Therapy" OR MH "Telerehabilitation" OR TI("rehabilitat*" OR "post acute car*" OR "postacute car*") OR AB("rehabilitat*" OR "post acute car*" OR "postacute car*") OR KW("rehabilitat*" OR "post acute car*" OR "postacute car*")	155,344
S2	MH "Aged+" OR MH "Aged, 80 and Over" OR MH "Frail Elderly" OR MH "Geriatrics" OR MH "Geriatric Psychiatry" OR MH "Gerontologic Nursing+" OR MH "Gerontologic Care" OR MH "Health Services for the Aged" OR TI("elder*" OR "eldest" OR "frail*" OR "geriatri*" OR "old age*" OR "oldest old*" OR "senior*" OR "senium" OR "very old*" OR "septuagenarian*" OR "octagenarian*" OR "octogenarian*" OR "nonagenarian*" OR "centarian*" OR "centenarian*" OR "supercentenarian*" OR "older people" OR "older subject*" OR "older patient*" OR "older age*" OR "older adult*" OR "older man" OR "older men" OR "older male" OR "older woman" OR "older women" OR "older female" OR "older population*" OR "older person*") OR AB("elder*" OR "eldest" OR "frail*" OR "geriatri*" OR "old age*" OR "oldest old*" OR "senior*" OR "senium" OR "very old*" OR "septuagenarian*" OR "octagenarian*" OR "octogenarian*" OR "nonagenarian*" OR "centarian*" OR "centenarian*" OR "supercentenarian*" OR "older people" OR "older subject*" OR "older patient*" OR "older age*" OR "older adult*" OR "older man" OR "older men" OR "older male" OR "older woman" OR "older women" OR "older female" OR "older population*" OR "older person*") OR KW("elder*" OR "eldest" OR "frail*" OR "geriatri*" OR "old age*" OR "oldest old*" OR "senior*" OR "senium" OR "very old*" OR "septuagenarian*" OR "octagenarian*" OR "octogenarian*" OR "nonagenarian*" OR "centarian*" OR "centenarian*" OR "supercentenarian*" OR "older people" OR "older subject*" OR "older patient*" OR "older age*" OR "older adult*" OR "older man" OR "older men" OR "older male" OR "older woman" OR "older women" OR "older female" OR "older population*" OR "older person*")	982,823
S1	"Advanced Practice Nurses" OR MH "Acute Care Nurse Practitioners" OR MH "Adult Nurse Practitioners" OR MH "Emergency Nurse Practitioners" OR MH "Gerontologic Nurse Practitioners" OR MH "Clinical Nurse Specialists" OR MH "Nurse Consultants+" OR MH "Nurse Managers+" OR MH "Nurse Counselors" OR MH "Nurse Liaison" OR MH "Nurses by Specialty" OR MH "RN First Assistants" OR MH "Nurses, Other" OR MH "Foreign Nurses" OR MH "Expert Nurses" OR MH "New Graduate Nurses" OR MH "Novice Nurses" OR MH "Practical Nurses" OR MH "Nursing Assistants" OR MH "Nursing Practice+" OR MH "Nursing Practice, Evidence-Based+" OR TI("nurse" OR "nurses" OR "nursing" OR "nurse's") OR AB("nurse" OR "nurses" OR "nursing" OR "nurse's") OR KW("nurse" OR "nurses" OR "nursing" OR "nurse's")	591,776

Search strategy for PubMed (4 August 2021)

Search Query	Results
#6 #1 AND #2 AND #3 AND #4 AND #5	689
#5 “Goals”[Mesh] OR “goal”[tiab] OR “goals”[tiab] OR “action plan”[tiab]	384,149
#4 “Methods”[Mesh] OR “methods” [Subheading] OR “Guideline” [Publication Type] OR “Guidelines as Topic”[Mesh] OR “Education”[Mesh] OR “Patient Education as Topic”[Mesh] OR “Education, Nursing”[Mesh] OR “Mentoring”[Mesh] OR “Clinical Protocols”[Mesh] OR “Patient-Centered Care”[Mesh:NoExp] OR “Patient Participation”[Mesh] OR “Motivation”[Mesh] OR “Hospitals/education”[Mesh] OR “Practice Patterns, Nurses”[Mesh] OR “intervention”[tiab] OR “method”[tiab] OR “methods”[tiab] OR “guide”[tiab] OR “guidance”[tiab] OR “education”[tiab] OR “coach”[tiab] OR “project”[tiab] OR “practice”[tiab] OR “protocol”[tiab] OR “standard”[tiab] OR “instrument”[tiab] OR “framework”[tiab] OR “model”[tiab] OR “models”[tiab] OR “mentor”[tiab] OR “task oriented train”[tiab] OR “canadian occupational performance measure”[tiab] OR “copm”[tiab] OR “goal attainment scal”[tiab] OR “patient involvement”[tiab] OR “patient empowerment”[tiab] OR “patient activation”[tiab] OR “patient engagement”[tiab] OR “patient cent”[tiab] OR (“patient”[tiab] AND (“collaborati” OR “directed” OR “led therap”[tiab] OR “regulated”[tiab])) OR “motivation”[tiab]	13,909,534
#3 “Rehabilitation”[Mesh] OR “rehabilitation” [Subheading] OR “Rehabilitation Nursing”[Mesh] OR “Rehabilitation Centers”[Mesh] OR “Rehabilitation Research”[Mesh] OR “rehabilitat”[tiab] OR “post acute car”[tiab] OR “postacute car”[tiab]	564,289
#2 “Aged”[Mesh] OR “Aged, 80 and over”[Mesh] OR “Frail Elderly”[Mesh] OR “Geriatrics”[Mesh] OR “Geriatric Psychiatry”[Mesh] OR “Geriatric Nursing”[Mesh] OR “Geriatric Dentistry”[Mesh] OR “Health Services for the Aged”[Mesh] OR “Nursing Homes”[Mesh] OR “elder”[tw] OR “eldest”[tw] OR “frail”[tw] OR “geriatri”[tw] OR “old age”[tw] OR “oldest old”[tw] OR “senior”[tw] OR “senium”[tw] OR “very old”[tw] OR “septuagenarian”[tw] OR “octagenarian”[tw] OR “octogenarian”[tw] OR “nonagenarian”[tw] OR “centarian”[tw] OR “centenarian”[tw] OR “supercentenarian”[tw] OR “older people”[tw] OR “older subject”[tw] OR “older patient”[tw] OR “older age”[tw] OR “older adult”[tw] OR “older man”[tw] OR “older men”[tw] OR “older male”[tw] OR “older woman”[tw] OR “older women”[tw] OR “older female”[tw] OR “older population”[tw] OR “older person”[tw]	3,532,321
#1 “Nurses”[Mesh] OR “Nursing”[Mesh] OR “Nurse-Patient Relations”[Mesh] OR “Nurse’s Role”[Mesh] OR “nursing” [Subheading] OR “Nurse’s Role”[Mesh] OR “nurse”[tiab] OR “nurses”[tiab] OR “nursing”[tiab] OR “nurse’s”[tiab]	683,240





CHAPTER 4

THE ROLE OF NURSING STAFF REGARDING GOAL SETTING AND ACHIEVING IN GERIATRIC REHABILITATION: A FOCUS GROUP STUDY

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Rehabilitation Nursing Journal. 2023

ABSTRACT

PURPOSE

The aim of this study was to explore and clarify the role of nursing staff in geriatric rehabilitation on supporting patients in goal setting and achieving, through reflecting on rehabilitation interventions.

DESIGN

A descriptive qualitative study was conducted.

METHODS

We conducted four online focus group interviews with 23 members of the nursing staff working in geriatric rehabilitation. They reflected on six interventions, preclassified into three types: setting goals in the admission phase, increasing patient participation in order to personalize the rehabilitation trajectory, and supporting patients in working on short-term goals. Data were analyzed using thematic content analysis.

RESULTS

Setting goals in the admission phase is primarily the task of the multidisciplinary team rather than the nursing staff. Interventions to increase patient participation align with the coordinating role of nursing staff in the rehabilitation team. Working on short-term goals is of great value to patients.

CLINICAL RELEVANCE TO THE PRACTICE OF REHABILITATION NURSING:

The connection between the patient's personal goals and professional treatment aimed at functional recovery can be enhanced by strengthening the position of nursing staff working in geriatric rehabilitation.

CONCLUSION

Members of nursing staff in geriatric rehabilitation see themselves playing a coordinating role in the multidisciplinary team, supporting the patient in goal work. Interventions aimed at advancing patient participation and providing support for short-term goals reinforce this role.

1 | INTRODUCTION

Older people can recuperate in special rehabilitation wards in nursing homes following an acute or subacute decrease in function after a medical event such as a hip fracture or stroke.¹ In 2019, 53,320 patients in the Netherlands were admitted to a so-called “geriatric rehabilitation facility,” their average length of stay being 42 days.² Van Balen et al.¹ describe two core principles of geriatric rehabilitation: working with an interdisciplinary approach in a multidisciplinary team and a structured and time-delimited rehabilitation plan focused on the goals of the patient. The multidisciplinary team includes an elderly care physician, a physiotherapist, a nurse, and an occupational therapist,³ and according to the patients’ needs, the team can be extended to include a speech therapist, a dietician, a psychologist, and a social worker.¹

In Dutch healthcare facilities for older people, geriatric rehabilitation is relatively new. In 2015, the healthcare system was changed from a long-term care government-guided reimbursement system without financial incentive for “efficient” geriatric rehabilitation toward a more market-guided bundled payment system.⁴ This change necessitated several activities aimed at professionalizing geriatric rehabilitation. For example, appropriate guidelines and care pathways have been developed for stroke and fractures.³ In addition, Tijssen et al.^{5,6} strive to identify and formalize factors that contribute to a challenging rehabilitation environment to optimize rehabilitation care.

Geriatric rehabilitation mainly takes place in nursing homes. Nursing staff in nursing homes in the Netherlands consist of registered nurses, but mostly certified nursing assistants.⁷ Compared to other countries, the Dutch-certified nursing assistant education is rather lengthy, specifically consisting of a 3-year practice-oriented course.⁸ Nursing staff were traditionally more focused on providing comfort in an environment where older people live, as opposed to working within a multidisciplinary team with patients on rehabilitation goals needed to safely return to home. Nursing home managers conclude that there are major differences between long-term care and geriatric rehabilitation, with different demands on the professionals involved.⁹ An increase in the number of registered nurses working in geriatric rehabilitation has been seen.¹⁰ One of the specific aspects that the nursing staff have been struggling with was voiced by De Vos et al.¹¹ They found that nursing staff in geriatric rehabilitation in the Netherlands experience a certain apprehensiveness about performing goal-centered care in multidisciplinary teams. Clear working procedures might help the nursing staff in taking on their role.¹¹⁻¹³

Vaalburg et al.¹⁴ performed a scoping review to explore the range of interventions on goal setting and achieving available to nurses in geriatric rehabilitation. The researchers found 11 interventions, of which six provide a sufficiently clear description of the nursing role in an inpatient rehabilitation setting (see Table 1). These six

Table 1. Interventions

Intervention Type 1,2 or 3	Author(s), year, Country, Name Intervention	Aim of Intervention	Intervention Description	Accompanying materials
Type 1 Interventions focused on goal setting with the patient in the admission phase using a scale	Ruland et al. ¹⁵ 1997 USA <i>Lorensen's Self-Care Capability Scale (refined)</i>	Tailoring nursing care decisions to desired outcomes as preferred by individual patients.	1 Patient is asked to name predominant problems and to indicate which are most important to relieve. 2. Nurse and patient assess performance on each self-care function with the help of <i>Lorensen's Self-Care Capability Scale</i>. 3. Together they select desired level of functioning and evaluate progress.	The Lorensens Self-Care Capability Scale comprises 13 dimensions of patient's self-care abilities.
	Smit et al. ¹⁶ 2018 The Netherlands <i>Collaborative Functional Goal Setting (CFGs)</i>	Facilitate the process of jointly setting goals by the use of a measurement instrument.	1. On admission, nurse completes Barthel Index (BI) or functional items of the Utrecht Scale for Evaluation of Rehabilitation (FUSER). Scale scores are presented in multidisciplinary meeting (MDM). 2. Multidisciplinary team set functional goals. 3. Goal-setting meeting with patient and physician / nurse practitioner. Patient is invited to set their own functional goals. Patient's goals are defined through shared decision-making between patient and physician. 4. Prior to every 2-weekly MDMs, new functional assessment is conducted by nurse. 5. During MDM the target scores will be reviewed. 6. Physician / nurse practitioner informs patient about the outcome of MDM.	Two standardized functional measurement instruments: the Barthel Index and the Utrecht Scale for Evaluation of Rehabilitation.
Type 2 Interventions focused on increasing patient participation in order to personalize the rehabilitation trajectory	Gual et al. ¹⁷ 2020 Spain <i>Motivational Interviewing (MI) intervention</i>	To empower, motivate and engage the person in planning and participating in the rehabilitation plan in order to improve rehabilitation outcomes, increase person satisfaction and self-efficacy	Four sessions of motivational interviewing by nurses: 1. Engage the stroke survivor in his/her care. 2. Co-create a personalized rehabilitation plan, complementing the routine geriatric rehabilitation plan. 3. Reinforce engagement and adherence to the plan to maintain behavior change and functional improvement.	Personalized rehabilitation plan agreed between stroke survivors and nurses based on stroke survivor's goals, needs, preferences and capabilities.

[continued on next page]

Table 1. [continued]

Intervention Type 1,2 or 3	Author(s), year, Country, Name Intervention	Aim of Intervention	Intervention Description	Accompanying materials
	Holliday et al. ¹⁸ 2007 Van de Weyer et al. ¹⁹ 2010 UK <i>Increased Participation</i>	Involving patients in goal setting in order to self-manage, maintain independence, and achieve the best possible quality of life.	Prior to admission: patient is given workbook that explains goal-setting process in detail. Day of admission: key worker (assigned to every patient) interview focused on patient experience to facilitate advocate role within goal setting. Week of admission: key worker works with patient to complete workbook. Friday of admission: week's goals set by therapists and patient working together. Patient present in goal-setting meetings. Short-term goals are reset on two or three weekly cycles.	Patient workbook in three sections: 1. Prioritize activity and participation domains. 2. Identify specific tasks within those domains patient wishes to work on. 3. Determining rehabilitation goals achievable within time frame of admission.
Type 3 Interventions are meant to support patients in working on daily goals	Huijben-Schoenmakers et al. ²⁰ 2013 The Netherlands <i>Map with prescribed exercises based on Stroke Guidelines</i>	Increase practice time of patients through nursing involvement.	Each week, exercises based on 4 interventions from the Clinical Nursing Rehabilitation Stroke Guidelines are adapted to individual goals, and rehabilitation level of the patient.	Exercises are documented in exercise map.
	Revello & Fields ²² 2015 USA <i>The Collaborative Patient Goal-Setting Initiative</i>	Better patient outcomes through nurse and patient collaborative goal setting.	1. Each day the nurse supports patient setting 1–2 goals they hope to achieve in the following 24-hour period. 2. The following evening, goal achievement is evaluated, and either the patient continues the previous goals or names new ones. 3. Nurses on other shifts and therapists acknowledge the goals with the patient and make an effort to see that the goals are met.	Whiteboards in patients' rooms.

interventions can be categorized into three types. The first type of interventions focuses on goal setting with the patient in the admission phase with the aid of a scale that measures the degree of independence in certain functions (Lorensen's Self-Care Capability Scale¹⁵ and the Collaborative Functional Goal Setting¹⁶). The second type of interventions focuses on increasing patient participation to personalize the rehabilitation trajectory using the Motivational Interviewing Intervention¹⁷ or the Increased Participation Intervention.^{18,19} The third type of interventions is meant to provide support for patients as they work on short-term goals with an exercise book or goals written on a whiteboard (map with prescribed exercises²⁰ based on the Dutch Stroke Guidelines²¹ or the Collaborative Patient Goal-Setting Initiative²²). It is unclear to what extent these six interventions, or aspects of these interventions, align with the professional view of nursing staff in geriatric rehabilitation in the Netherlands on the role they could play in the multidisciplinary team with patients' goal setting and achieving. With the aim to further explore and clarify this role, a focus group study was designed with geriatric rehabilitation nurses. The six interventions, as well as their underlying vision and elaboration in activities, were used as a means to reflect on this role.

2 | METHODS

This descriptive qualitative design study used focus group interviews with nursing staff working in geriatric rehabilitation to explore perspectives on their role in working with patients on their rehabilitation goals. The study followed the 32-item Consolidated Criteria for Reporting Qualitative Research formulated by Tong et al.²³

2.1 | SAMPLE

Participants were recruited through a purposive sampling strategy. Supplying potential participants with an invitation leaflet with information about the purpose and procedure of the focus groups, we contacted nursing home managers and senior staff members of two research networks (UKON and UNO Amsterdam) and a quality network (GRZ E-cademy). The managers and senior staff were asked to approach "outstanding" members of their nursing staff and encourage them to volunteer for the focus groups. "Outstanding" was described as "visibly concerned with their profession and preferably in the possession of a rehabilitation nursing diploma or similar qualification." The other inclusion criterion was working in inpatient geriatric rehabilitation. To the participants who volunteered, four different dates for focus groups were provided. Participants chose a group based on their schedule. Participants received a €10 voucher for cosmetics.

2.2 | INFORMATION AND INTERVIEW GUIDE

A semi-structured interview guide was developed by all authors (AMV, EW, PB, CH, RG). The guide consisted of three questions: (1) Does this intervention/part of the

intervention meet the needs of patients in your practice? (2) Does this intervention/part of the intervention fit the role of nursing staff? (3) Which preconditions are needed to use this intervention in practice? The interview guide was tested in a pilot session with one nurse and three nursing students on a geriatric rehabilitation ward. No revisions were suggested to the guide; however, some revisions were made to the PowerPoint that was used to present the six interventions.

2.3 | PROCEDURE

Four online focus group interviews were conducted in April and May 2022. All focus group interviews were moderated by one researcher (AMV); PB took notes to provide feedback to the moderator. After introducing the six interventions, divided into three types, participants were asked to reflect on the three types by initially writing down their thoughts on a digital whiteboard. This step provided each participant with an equal opportunity to contribute to the quest for which these focus groups were designed. The written information helped the moderator select topics and invite quieter participants to clarify their notes. Each focus group had five to seven participants. The interviews lasted about 120 minutes, were audio-recorded, and were transcribed verbatim.

2.4 | ANALYSIS

Data were analyzed using thematic content analysis,²⁴ which aims to provide a “map” of the content of the data set and an overview of variation and regularities within the data. To maintain rigor, analyses were independently performed by two researchers (AMV, PB).²⁵ The analysis started with thoroughly reading the transcripts and the written comments on the digital whiteboard to become familiar with the data. Then, the transcripts and written comments were read sentence by sentence, and quotes that appeared to answer one of the three key questions were included in a matrix set up for the analysis. Subsequently, the assembled quotes were read, and words that appeared to articulate key thoughts were highlighted. Based on the highlighted fragments, notes were made to catch the first impressions, thoughts, and initial analysis. From these notes, a coding tree was developed by two of the researchers (AMV, PB). With the other authors (EW, CH, RG), the interim analyses were discussed, while constantly reflecting on potential author bias.

2.5 | ETHICS

This study was not subject to the Dutch Medical Research Involving Human Subjects Act; therefore, it did not undergo a review by a medical ethics committee.²⁶ After being given information about the study, the participants gave consent for the audio recording of the interviews and for their personal data to be retained. No family names or other person-level information that can be traced back to individuals were used in the transcriptions.

Table 2. Characteristics of the Focus Group Participants.

Participant	Focus group	Age (years)	Level of basic nursing education	Advanced training in rehabilitation**	Working years in geriatric rehabilitation
#1	1	53	EQF*4	+	15
#2	1	49	EQF6	-	17
#3	1	39	EQF4	-	8
#4	1	52	EQF4	+	7
#5	1	56	EQF4	+	11
#6	2	28	EQF4	+	8
#7	2	26	EQF4	+	6
#8	2	41	EQF6	+	11
#9	2	26	EQF6	-	1
#10	2	30	EQF4	-	5
#11	2	46	EQF3	+	22
#12	3	42	EQF4	-	2
#13	3	39	EQF4	-	1
#14	3	37	EQF6	+	13
#15	3	52	EQF4	+	9
#16	3	50	EQF4	+	4
#17	3	53	EQF3	-	4
#18	3	60	EQF4	+	4
#19	4	27	EQF6	+	5
#20	4	47	EQF6	-	6
#21	4	26	EQF4	+	4
#22	4	26	EQF6	-	7
#23	4	36	EQF4	-	10
		Mean 40,9	2 (EQF3) 14 (EQF4) 7 (EQF6)	+ 57%	Mean 7,8

Notes *EQF = The European Qualifications Framework (EQF) describes levels of qualification ranging from basic (Level 1) to advanced (Level 8). EQF 3= certified nursing assistants completed 3 years of practice-oriented nursing education in a regional education center for vocational training; EQF 4= vocational nurses completed 3,5–4 years of nursing education in a regional educational center for vocational training and are registered in the Dutch Register for care professionals (so called BIG register); EQF 6 = nurse with bachelor's degree obtained from a university of applied sciences and registered in the Dutch Register for care professionals. **Continuing education in geriatric rehabilitation for both nurses and certified nursing assistants exists and often takes place on the initiative of the healthcare institutions where they are employed.

3 | RESULTS

A total of 23 members of nursing staff working on geriatric rehabilitation wards participated. Table 2 gives an overview of the participants' general characteristics. Table 3 summarizes the results of the study.

3.1 | INTERVENTIONS TYPE 1: SETTING GOALS IN THE ADMISSION PHASE

The first two interventions use scales to collaboratively set goals with the patient in the admission phase (see Table 1), specifically the Barthel Index,²⁷ the Utrecht Scale for Evaluation of Rehabilitation,²⁸ or Lorensen's Self-Care Capability Scale.¹⁵ The different scales are composed of items focusing on self-care abilities and mobility.

3.1.1 | PATIENTS' NEEDS

Participants saw the value of these interventions for patients. Collaboratively setting goals promotes patient engagement:

...If you use the Lorensen Scale, the patient might think, "Oh, what are my problem areas?" By showing them those areas, you can also involve them in setting the goals. I think they will then be more motivated to achieve those goals, because they had a role in defining them. (Participant 9)

At the same time, participants identified factors that hinder the geriatric patient from actively participating in the goal-setting process, the main factor being cognitive impairment and its consequences. Patients are not always able to oversee the situation, to plan, or to retain information.

3.1.2 | ROLE OF NURSING STAFF

Setting goals is usually done by the multidisciplinary team, with each discipline focusing on their own field of expertise, and not by the nursing staff. When it comes to goal setting during the admission phase, participants describe their role as coordinating:

I think as a nurse you are, especially in the multidisciplinary team, a cog in the wheel, you're there most of the time. We do the admission and we check all kinds of things, and in the case of pressure sores, we inform the occupational therapist: please come and see the patient today, and if the patient does not need a wheelchair, she can come a day or two later. We try to coordinate, to direct.... (Participant 16)

The role of nursing staff is to assess the extent to which the multidisciplinary team should take over control from the patient in the admission phase, to decide whether temporary goals need to be set that are checked with the patient at a later stage and

whether, in this stage, the family should be questioned about goals. The family supplies the multidisciplinary team with essential information about the patient and their needs. Concurrently, they, like the patient, need to be informed about rehabilitation and its possibilities and limitations. Cooperating with family was seen by the participants as an important task of nursing staff.

Reflecting on these interventions, participants made clear that, in the admission phase, certain nursing focus points are regularly missed, such as wound care and medication management, because they do not belong to the expertise of the other rehabilitation professionals.

...within the geriatric rehabilitation there's a lot of goal setting from the disciplines. It's big, walking, the occupational therapist who's busy cooking, for example. But a care team, yes, the catheters, all the nursing supplies, [...] teaching someone to go home with the catheter and emptying it. Those are all goals that are often, yes, forgotten. (Participant 3)

3.1.3 | TERMS AND CONDITIONS FOR IMPLEMENTATION OF INTERVENTIONS TYPE 1

Participants considered collaboratively setting goals with a scale to be the responsibility of the multidisciplinary team as a whole and not as a specific task of nursing staff. They did, however, have ideas about measures to facilitate this collaborative setting of goals with the patient, for example, a multidisciplinary intake to avoid overlapping questions and thus unnecessarily burdening the patient, giving the patient time to acclimatize and unwind after traveling from the hospital, and postponing the goal setting till the second or third day after admittance. Whoever on the multidisciplinary team uses the instruments, such as the Utrecht Scale for Evaluation of the Rehabilitation,²⁸ the Barthel Index, and Lorensen's Self-Care Capability Scale, should be trained. Attention should be paid to the added value of using such an instrument.

3.2 | INTERVENTIONS TYPE 2: INCREASING PATIENT PARTICIPATION

The second two interventions focus on increasing patient participation during the rehabilitation process in order to personalize the rehabilitation trajectory (see Table 1).

3.2.1 | PATIENTS' NEED

Participants see the multidisciplinary team meetings as appropriate moments to encourage patient involvement, as is done in the Increased Participation Intervention.^{18,19} Similar to the admission phase, participants stated that, during rehabilitation, patients need to be supported in order to be optimally involved. One of the participants gave an example of how this is done on her ward.

In preparation of the multidisciplinary team meeting, we give the patient a short questionnaire. We have been doing this for two weeks now, because we would

like to include more person-centered elements and know: “what are the patient’s goals and are they realistic?” [...]. These two weeks we’ve received 10 completed forms, and it’s really good to see that patients come up with: “I’m scared.” Something that has not come up in daily practice. (Participant 22)

This questionnaire has the same goal as the sessions in the Motivational Interviewing Intervention: “active listening to persons’ concern and adaptation to the rehabilitation plan”.^{17(p5)}

3.2.2 | ROLE OF NURSING STAFF

Participants’ practices do not include patient attendance at the multidisciplinary team meetings, as is part of the Increased Participation Intervention, or a set number of planned meetings between nursing staff and the patient, as is done in Gual et al.’s Motivational Interviewing Intervention¹⁷. However, supporting the patients to participate, in order to make the rehabilitation process as person-centered as possible, is seen as a central feature of the work of nursing staff and is ingrained in their practice because of their 24/7 presence on the ward.

Your contact with the rehabilitant, being the first point of contact, helps the rehabilitant by explaining the rehabilitation in understandable language and motivates them to rehabilitate. Looking for the intrinsic motivation... (Digital whiteboard comment)

The role of nursing staff was described as “helicopter,” “connector,” and “coordinator” on several levels, for example as an interpreter of jargon.

We are the link between the patient and the rest. Because they all talk medically, and they all have their goals, and the patient is sitting there flapping his/her ears. And you are the one who has to say: If this is it, then we are going to do it like this.... (Participant 4)

Another explanation of the concept of connector is the connecting link between professional goals and patients’ lives:

With the helicopter view, I mean to say: What’s in it for the rehabilitant? What’s important for them? [...] we once had someone from the country, [...] he had to learn to walk, but this man just wanted to sit in his chair and pull potatoes out of the ground. And not the walking. (Participant 2)

The premise that “everything is rehabilitation” needs to be explained to patients. This is a third interpretation of the connecting or more precise, integrating role.

Table 3. Results.

	1.Do (part of) these interventions meet the needs of patients in your practice?	2. Do (part of) these interventions fit the role of the nurse?	3.Which preconditions are needed to use (part of) these intervention(s) in practice?
Intervention Type 1 Collaboratively setting goals in the admission phase with the aid of a measurement instrument	Collaboratively setting goals promotes patient engagement. Participation by patients in the goal-setting process is hindered, mainly by cognitive impairment. Patients need to be helped in providing optimal input.	Setting goals is usually done by the multidisciplinary team, not by the nurse. The nursing role in this phase is coordinating. The role of the nurse is to assess the extent to which control should be taken over from the patient in the admission phase. Cooperating with family is an important nursing task. In the admission phase certain nursing focus points are missed.	Measures have to be taken to make participating in collaborative goal setting possible for the patient. To work with goal setting instruments in the admission phase, training is needed which includes explanation of the added value of the instruments.
Intervention Type 2 Increasing patient participation during the rehabilitation process	Multidisciplinary team meetings are appropriate moments to involve patients. Patients need to be helped in providing optimal input.	Supporting the patients to participate in order to make the rehabilitation process as person centered as possible, is a central feature of the nurses' work. The nurse connects in multiple ways: - by translating jargon - by linking professional goals and patients' lives - by explaining that every activity can be seen as rehabilitation, etc.	Being able to have motivational conversations is a key skill. Nurses should work consistently with rehabilitation plans. Working with integrated goals instead of discipline-specific goals supports the coordinating role of the nurse. Not feeling in the position to take on a coordinating role in the multidisciplinary team.
Intervention Type 3 Supporting patients in working on short term goals	Clear short term goals have many benefits for the patient: - short term goals make rehabilitation manageable - achieving small goals motivates - patients do not have to wait for the next therapy session to exercise - small goals help families take on supportive role - small goals support interprofessional collaboration and provide a consistent team approach, which in turn is clarifying for the patient.	Management of these interventions is the responsibility of other disciplines. The nurses' role is to monitor progress and inform other disciplines about progress. Differing opinions about whether stimulating the patient to exercise is the nurses' task: "extra" workload versus most exercises fit in daily activities. Interventions are a means of involving family which is as seen as an important nursing task.	Exercise sheets and whiteboard with short-term exercises need to be kept up to date to ensure continuity.

[continued on next page]

Table 3. [continued]

Preconditions for all three types	Care pathways and work procedures describing the nurse's and patient's role securing the patient's participation and the specific nursing contribution.
Time to apply the interventions.	Education in geriatric rehabilitation.
	Nursing leadership.

They see going to the physiotherapist as rehabilitation, unlike washing and getting dressed, and we are responsible to make them understand: How will you manage in the future? (Participant 8).

In addition, the role of nursing staff was defined as “motivator” or “driving force” for the patient, and virtually, all participants mentioned the importance of being able to have motivational conversations as a key skill.

And as for Intervention 4 [Motivational Interviewing Intervention¹⁷, AMV]...you do this constantly. From the conversations you hear a lot and often find out why a client is struggling with something or why things don't work out. (Digital whiteboard comment)

3.2.3 | TERMS AND CONDITIONS FOR IMPLEMENTATION OF INTERVENTIONS TYPE 2

Education in motivational interviewing was emphasized by participants as a prerequisite to help members of the nursing staff make the transition from caring for patients to coaching them to work on their personal goals. Another prerequisite is that nursing staff should consciously work with plans; otherwise, they will not be able to support the patient in participating in the rehabilitation process and play a coordinating role:

I think half the team is not aware of treatment plans. (Participant 10)

Nursing staff have the potential to play a coordinating role, being closest to the patient and always in a position to talk about and observe their progress. Participants named several factors that stand in the way of the coordinating role, such as working with discipline-specific goals and the lack of an integrated rehabilitation plan.

...it is very much discipline-oriented. In the treatment plan the occupational therapist makes a goal, the physiotherapist makes a goal, [...]. And if it's about walking [...] the nurse automatically is of less importance. (Participant 3)

Also, not all nurses feel in a position to play a coordinating role in the rehabilitation process, as illustrated by the last quote.

The therapist focuses on the therapy, but I expect the nurses to observe: “This patient has had a couple of down days. I do not think it realistic to send him home yet.” [...] But we do not always see a possibility to utter this.... (Participant 8)

3.3 | INTERVENTIONS TYPE 3: SHORT-TERM GOAL SUPPORT

Finally, two interventions meant to support patients in working on short-term goals were discussed with the focus group participants (see Table 1).

3.3.1 | PATIENTS’ NEEDS

Participants saw many advantages for the patient in working with interventions that support working on short-term goals, such as exercise goals on whiteboards or exercise sheets. Short-term goals make rehabilitation manageable, achieving small goals motivates, patients do not have to wait for the next therapy session to exercise, and it helps families take on a supportive role. Ultimately, these interventions support interprofessional collaboration on goals and thus provide a consistent team approach, which in turn is clarifying for the patient.

I think the exercise sheet is also a nice method, because the patient has exercises at hand at any time of the day/week and does not have to “wait” for the therapy moments of the physio/ergo/etc. (Digital whiteboard comment)

3.3.2 | ROLE OF NURSING STAFF

In general, the initiative and management of these interventions, such as exercise goals on whiteboards or exercise sheets, were considered the responsibility of other disciplines. The role of nursing staff is to monitor progress and inform other disciplines about progress. Participants had differing opinions about whether stimulating the patient to exercise is the nurses’ task. Some see this as “extra” workload; others emphasized that if you work according to the philosophy that “everything is rehabilitation,” most exercises fit into daily activities. Involving family in the rehabilitation process was seen as an important nursing task.

3.3.3 | TERMS AND CONDITIONS FOR IMPLEMENTATION OF INTERVENTIONS TYPE 3

Exercise sheets and whiteboard with short-term exercises need to be kept up-to-date to ensure continuity.

3.4 | TERMS AND CONDITIONS FOR ALL THREE TYPES OF INTERVENTIONS

Some of the conditions for implementation mentioned by the participants apply to all interventions. First, time is needed to actually apply the different interventions, and second, care pathways and work procedures describing the role of nursing staff and the

patient's role secure the patient's participation. It legitimizes certain activities, such as patient attendance at the multidisciplinary team meeting or having motivational interviewing sessions, and makes these activities less team dependent. Third, the need for education in geriatric rehabilitation was mentioned in all focus group interviews. Educating nursing staff promotes working with a rehabilitation mindset.

Some have worked in this department for nearly a hundred years and are a fixture, but only now [after the geriatric rehabilitation education, AMV] they realize: I may not be attending the multidisciplinary team meeting [...] or I am not the case manager of this rehabilitant, but I am on a nightshift and I notice that getting in and out of bed by himself is not going well yet. So I might ask: "how do you think you will manage at home?" So they have a much better understanding of all aspects of rehabilitation that are also needed at home, and they dare to take more control of it. (Participant 22)

Participants mentioned that attending training has important outcomes, such as nursing staff become more aware of the quality of their work, and it contributes to the leadership of the geriatric rehabilitation nurse. Leadership is a fourth condition for the successful implementation of interventions. The participants made an appeal to all nursing staff working in geriatric rehabilitation to be aware of and show their expertise:

...what can help them take that role? I think...awareness among nurses that they are important. (Participant 4)

So you take on that role by directing and participating in the whole process. And I think if you do that, your colleagues, the other disciplines, well, you show them that: Hey, I know what I'm talking about. (Participant 5)

4 | DISCUSSION

The aim of this focus group study was to explore and clarify the role of nursing staff working in geriatric rehabilitation on supporting patients in goal setting and achieving. This work was done through reflecting on interventions meant to support goal setting and achieving in geriatric rehabilitation.

4.1 | MATCHING PATIENTS' NEEDS

Collaboratively setting goals in the admission phase with the help of a scale (Type 1) increases patients' awareness of why they are in this healthcare setting and of the goals they could be working on. The same is true for fostering patient involvement in the rehabilitation process (Type 2). This could be supported by the use of an instrument like a short questionnaire about progress on goals. According to the participants in this study, interventions providing support for short-term goals (Type 3) have many benefits

for patients. Taking into account the characteristics of the older patient, the situation (post-acute), and the short time frame in which the treatment must take place given the limited reimbursement, these interventions make rehabilitation manageable for the patient and help the family to take on a supportive role. This is confirmed in various ways by other studies. Turner-Stokes et al.²⁹ studied a method in which short-term goals toward the identified key goal objectives were set and reviewed at fortnightly intervals. They found that patient goal engagement improved significantly between admission and discharge. In addition, the evaluation tool for geriatric rehabilitation, developed by Janssen et al.,³⁰ confirms the appropriateness of working with small goals. Two of the evaluation tools' criteria are "Rehabilitation goals are continuously coordinated with the client" and "Informal caregivers are explicitly involved in the therapy and are aware that they can practice with the client".

4.2 | ALIGNING WITH THE ROLE OF NURSING STAFF

For the nursing staff, there are three aspects of importance in applying all six interventions (Types 1, 2, and 3), and these are evident from the feedback of the participants. The first aspect is the delicate process of estimating the amount of control a patient is able to take in the goal-setting process, tuning in on that level of control and establishing conditions for the patients to take as much control as possible. Research by Thompson³¹ demonstrates that this is consistent with what patients want. Although patients prefer greater involvement in decision-making, they expect professionals to recognize that the amount of involvement varies according to the circumstances.

The second aspect that emerged from the participants is involving family in the process. Participants stressed the important role of family in setting goals as well as in working on goals. Remarkably, this aspect is only marginally described in the papers about the interventions. Dahkle et al.³² explored interprofessional staffs' perceptions of interprofessional collaboration and patient-centered care and confirmed the importance of incorporating family. In both of these aspects, tuning in on the level of control a patient is able to take and involving family, the participants seemed confident and competent.

The third aspect the focus group interviews revealed that interventions that focus on advancing patient participation during the rehabilitation process (Type 2) align well with current practice. The participants expressed that they play a linking role between the patient's personal goals and professional treatment aimed at functional recovery. This does not come as a surprise. Two of the four functions in the theoretical framework of Kirkevold,³³ which describes the nursing role in stroke rehabilitation—namely, the interpretative and the integrative function—are at their core connective in nature. Through the interpretive function, the nurse helps the patient to interpret the situation by providing them with individually adjusted information. The integrative function refers to the nurse helping the patient to transfer learned techniques to daily activities.³³ The

focus group interviews revealed that to optimally take on this connecting, coordinating role, interprofessional cooperation must be further developed. For example, rehabilitation plans are as yet mostly an assembling of discipline-specific goals and do not encourage nursing staff taking on a coordinating role. The current practice of working as separate disciplines is also illustrated by the participants' ambivalence about the third type of interventions, providing support in working on short-term goals.

Participants emphasized the benefits of working on short-term goals with patients but hesitate to incorporate this into their nursing practice, thus missing the opportunity to be the center of all disciplines. In the research literature, there are three factors that influence this issue and impede the nurse from taking on a coordinating role. All three factors were mentioned by the participants. First, Sinclair et al.³⁴ emphasized the added value of interprofessional collaboration on patient-centered goals. This stimulates the different healthcare professionals, including the nurse, to share their knowledge and skills and thus synergistically influence the patient care provided. Second, Dahlke et al.³² describe that time and a perceived power imbalance between disciplines can hinder collaboration and lead to a focus on purely medical issues. Implementing the investigated interventions aimed at advancing patient participation in the rehabilitation process (Type 2) and providing support for patients in working on short-term goals (Type 3) help formalize nursing tasks and responsibilities. Educating nurses in rehabilitation is an important third factor for performing the connecting role optimally. Several authors emphasize the need for specialized education.^{35,36} This fosters role recognition, which, according to Doornebosch et al.³⁷, is a main facilitator of interprofessional care in geriatric rehabilitation.

4.3 | STRENGTHS AND LIMITATIONS

A strength of the study is that the subject was of interest to many nursing staff working in geriatric rehabilitation. Recruiting for the focus group interviews went very smoothly. This underscores the relevance of this issue. Another strength is the use of the digital whiteboard at the start of the focus group interviews. This gave quieter participants an extra chance to voice their ideas. The study is limited because participants expressed their ideas about the interventions mainly based on their imaginative abilities. To fully understand the contribution of the nursing interventions to a more patient-centered and efficient interprofessional process, the application of these interventions should be the subject of further research.

4.4 | IMPLICATIONS FOR PRACTICE

The results from the focus groups made clear that setting goals with the aid of a scale is primarily the task of the entire multidisciplinary team rather than that of the nursing staff. In this multidisciplinary process, specific nursing focus points are currently missing and should be incorporated into the admission process. Interventions focused on advancing patient participation (Type 2) align clearly with the coordinating role of

nursing staff in the rehabilitation team. Participants emphasize the benefits of working with short-term goals (Type 3) for patients. To incorporate these into their nursing practice and strengthen the coordinating role, interprofessional teamwork needs to be further developed, available interventions should be implemented, and nursing staff should be trained in rehabilitation. Lastly, the needs and role of family in geriatric rehabilitation deserves to be embedded in interventions.

5 | CONCLUSION

The role of nursing staff in geriatric rehabilitation in the Netherlands is evolving. Reflecting on the three types of interventions helped to further clarify this role. Nursing staff working in geriatric rehabilitation see themselves playing a coordinating role in the multidisciplinary team, supporting the patient in goal work. Interventions aimed at advancing patient participation (Type 2) and working toward goals (Type 3) reinforce this role.

KEY PRACTICE POINTS

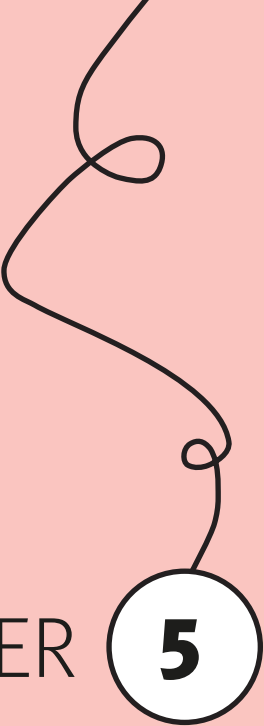
- Goal setting in the admission phase is a multidisciplinary responsibility. Specific nursing focus points should be incorporated into the admission goal-setting process.
- To optimally support patients in achieving goals, interprofessional collaboration needs to be further developed.
- The needs and role of family in geriatric rehabilitation deserve to be embedded in interventions.

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CHAPTER

5

PARTICIPATORY ACTION RESEARCH TO ENHANCE PATIENT-CENTRED GOAL SETTING IN GERIATRIC REHABILITATION: A NURSING TEAM'S QUEST

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ABSTRACT

AIM

The aim of this study was to provide insights into how, through exploring goal-setting interventions, a nursing team in geriatric rehabilitation might refine their patient-centred strategies.

DESIGN

The study design was participatory action research (PAR).

METHOD

Team members and nursing students, under the guidance of a facilitator, performed two PAR cycles. In the first cycle, the action phase consisted of preparing a multidisciplinary team meeting (MTM) with a patient. In the second cycle, based on the evaluation of the first, the participants worked with goals on a whiteboard in the patient's room. The data were collected in The Netherlands between February 2020 and June 2022. The data collection methods included the facilitator's logbook, observations, (group) interviews, charting activities and short surveys. Data analysis was conducted in weekly team sessions. The Guidelines for Best Practices in the Reporting of Participatory Action Research were followed.

RESULTS

In the first PAR cycle, the team learned that preparing an MTM with a patient did not enhance the patient's engagement in achieving their rehabilitation goals, but it was beneficial for the nurses' intermediate role between the patient and the multidisciplinary team. Clarity about responsibilities in the multidisciplinary team was a prerequisite for nurses to take on this role adequately. In the second PAR cycle, it became clear that working with a whiteboard in the patient's room had a positive effect on the patient's engagement in the rehabilitation process, and the nurses gained knowledge about a broader variety of professional rehabilitation domains.

CONCLUSION

Through PAR, the nursing team learned two lessons: cooperating with patients through MTM preparation and working with whiteboards enhanced their patient-centredness, but patients needed tangible goals to become engaged in their rehabilitation planning.

IMPLICATIONS FOR THE PROFESSION AND PATIENT CARE

- Prepare the multidisciplinary team meeting with the patient, as discussing rehabilitation goals can indirectly boost motivation by making older patients feel seen and heard, even if they seem unable to fully participate in the conversation.
- Clarify responsibilities in the multidisciplinary geriatric rehabilitation team. This is a prerequisite for nurses to take on an advocacy role for patients in multidisciplinary team meetings.
- To enhance patient-centred care, consider working with tangible goals on a whiteboard in the patient's room.

1 | INTRODUCTION

Patient-centredness is considered to be a core principle of the geriatric rehabilitation process. An important aim of geriatric rehabilitation facilities is to enable people to retain their independence for as long as possible and to maximise societal participation.¹ To achieve this goal, services consider the patients' social circumstances as well as their functional abilities, viewing patients holistically rather than focusing solely on specific diagnoses.^{1,2} According to Kvæl et al.,² the main strategy to facilitate this holistic patient-centred approach is to focus on patient involvement. Castro et al.^{3(p7)} defined patient involvement as 'a patient's rights and opportunities to influence and engage in the decision making about his care through a dialogue attuned to his preferences, potential and a combination of his experiential and the professional's expert knowledge'. In geriatric rehabilitation, a shared principle is to create a patient-centred rehabilitation plan.^{1,4} Ideally, this plan is constructed by setting rehabilitation goals via a dialogue with each patient to ensure their preferences are assigned the appropriate priority.^{1,5} In addition, the creation of goals that hold personal significance—a process that involves individuals actively setting their own goals and communicating about these goals—has been linked to greater ownership of these goals, enhanced motivation to engage in subsequent rehabilitation activities and improved overall rehabilitation outcomes.⁵⁻⁷

Patient-centred work that involves rehabilitation goals is not self-evident. Indeed, authors have highlighted challenges related to practising patient-centred goal setting, and poor patient engagement is often to blame. Smit et al.⁸ tested a new patient-centred goal-setting method for geriatric rehabilitation. The patients felt that the professionals largely dictated the steps towards discharge, and these steps were often unclear or not transparent to the patients. This view was confirmed in a longitudinal qualitative study by Lubbe et al.⁹ Moreover, research on geriatric rehabilitation and patient characteristics has revealed several aspects that might influence patient engagement. First, the average patient in this setting is portrayed at admission as being in a rather 'fragile state' due to their reason for rehabilitation. This state diminishes their ability to engage in goal discussions, reducing their involvement in the process.¹⁰⁻¹² Van Balen et al.⁴ stated that delirium is one of the most important comorbid conditions in patients who are suitable for geriatric rehabilitation. Second, Rosewilliam et al.⁶ introduced other disempowering factors, including a lack of confidence because of not being 'on home ground' and fear of being branded a 'troublesome patient'. Another challenge for shared goal setting is that it is usually new to patients in geriatric rehabilitation, making it difficult for them to understand what is expected of them.^{10,13} Patients do not expect to be active and to have a role in decision making,⁶ and they do not expect to perform daily activities themselves.¹² Lubbe et al.⁹ found that the level of involvement differs for each person: while some want a more active role, others prefer the professional to take the lead. Moreover, most patients gain an increasing grip on their situation during their rehabilitation process.^{9,11}

Based on earlier research, nurses can play a pivotal role in supporting patient involvement in the process of goal setting.¹⁴ The primary aim of this support is to enhance the patient's understanding of their situation. Rose et al.¹³ highlighted several supportive and educational tasks nurses can perform, such as clarifying the meaning of 'goal', outlining what to expect in goal-setting meetings as well as the patient's potential role, helping patients divide long-term goals into manageable steps, guiding patients in organising exercise schedules and summarising key points from discussions. Additionally, nurses apply skills from exercise sessions to everyday situations, making these sessions personally significant and thus also supporting active goal attainment activities.¹⁵ However, the increased acuity and complexity of patients admitted to inpatient rehabilitation units require nurses to focus more on general clinical care rather than rehabilitation care. This shift hinders a consistent, goal-oriented approach to rehabilitation.¹⁶ To support the above-described role of a nurse, clear working methods that involve patients in their goal setting are necessary.^{17,18}

On a geriatric rehabilitation ward in the Netherlands, a nursing team set out to improve their patient-centred care by exploring how different working methods concerning goal setting and achievement can enhance patient involvement. They used participatory action research (PAR) for this endeavour. In our previous publication, we described this PAR process and evaluated the outcomes of involving nurses, as well as what hampered and facilitated collaboration between the nursing team and the researcher/facilitator (Vaalburg et al. 2024).¹⁹

2 | BACKGROUND

The guiding principle in healthcare 'quality thinking' is to improve care based on reflecting and learning together with those involved. In PAR, participants and researchers undertake collective, self-reflective inquiry to improve their practices.²⁰ This iterative approach allows for the implementation of informed strategies, followed by further research to evaluate the outcomes. Empowering nursing professionals to actively engage in research fosters a culture of involvement and encourages them to voice and exchange their insights regarding effective practices. This collaborative approach can yield invaluable knowledge and expertise in navigating specific challenges within the field.²¹ We selected PAR over other more traditional qualitative methods (e.g., ethnography and interviews). Although those methods might also facilitate our understanding of the process of enhancing patient involvement through goal setting, they position researchers as external observers and do not involve people in the situation under study. Hence, using those methods would not enable the nursing team to refine their patient-centred strategies, which was our aim.

This PAR was initiated by a nursing professor (R.J.J.G.) in collaboration with the manager of the geriatric rehabilitation unit at the nursing home. Their ambition was to enhance

professionalisation of nursing care in geriatric rehabilitation. They assigned to the team the subject of improving their goal-setting practice, considering this to be a key contributor to patient-centred care. In the present paper, we describe the activities the nursing team carried out to explore the challenges concerning patient involvement through goal setting in geriatric rehabilitation using PAR.

3 | THE STUDY

The aim of this PAR was to provide insight into how a nursing team in geriatric rehabilitation can best promote patient-centredness by involving patients, using goal-setting activities as a means.

3.1 | DESIGN

The PAR was performed in two cycles, each consisting of five steps: orientation, diagnosis, development, action and evaluation. In the first cycle, a manual for preparing the multidisciplinary team meeting (MTM) with patients was designed and evaluated. In the second cycle, nurses and nursing students performed a pilot study on writing rehabilitation goals on a whiteboard in the patient's room. The findings are reported according to the recommendations of Smith et al.²² (see Appendix 1). This paper describes the key elements of the project (e.g., the timeframe, the participants [and the nature of their roles], the process followed, the project outcomes and emergent actions, the timelines and tables to convey the project design), the experiences of the participants, and the challenges and limitations of this project.

Table 1. Nursing team members during the PAR.

Date	Team lead (RN)	Apprenticeship track students in training to become CNAs*	CNA*	RN**	Supernumerary bachelor's nursing students	Total
Period 1: 1 Feb. 2020	1	2	6	4	3	16
Period 2: 1 Sept. 2020	1	4	4	3	3	15
Period 3: 1 Feb. 2021	1	2	5	5	4	17
Period 4: 1 Sept. 2021	1	2	5	6	4	18
Period 5: 1 Feb. 2022	1	0	6	6	3	16

RN = Registered nurse;

CNA = Certified nursing assistant.

* Compared to other countries, Dutch certified nursing assistant education is rather lengthy, consisting of a 3-year practice-oriented course.²⁵

** Part of the team not mentioned in this table is a group of, on average, six RNs that mainly work evening, night, and weekend shifts, bearing nursing responsibility for the entire nursing home. This group was not actively involved in the PAR.

3.2 | STUDY SETTING AND PERIOD

This study was carried out on a geriatric rehabilitation ward (specialising in neurological and oncological rehabilitation) of a nursing home in the Netherlands. This ward had a capacity of 20 patients. Patients were admitted for post-acute rehabilitation; most of them had pre-existing functional deterioration or specific care needs. In the Netherlands, the average length of stay on a geriatric rehabilitation ward is 42 days.²³ The nursing team consisted of an average of 18 nurses, of whom 12 actively participated in the PAR (see Table 1). At the start of the study, a Learning and Innovation Network (LIN) was installed on the ward: To improve the quality of care, three to four nursing students were added to the team for 20-week internships. Nurses and nursing students worked together on practice-based projects, constantly reflecting, learning and combining best practices, research evidence and patient perspectives.²⁴ This PAR took place from February 2020 to June 2022.

3.3 | RESEARCHER

A lecturer practitioner, a former registered nurse, facilitated the PAR process. She was present on the ward 1 day per week to support the nursing team in their action research activities, and she also provided educational sessions. The facilitator had a guiding role, aligning the team sessions as much as possible to the issues occurring in the work of the nurses, recapping the outcomes of the sessions and proposing the next steps in the process.

3.4 | PARTICIPANTS

There were four types of participants; in practice, the tasks of these different groups were intertwined. First, a core work group was established that consisted of a team lead and two senior team members of the nursing staff. This group made plans, monitored progress, discussed barriers and evaluated the project steps with the facilitator. If a team member was absent temporarily, then another team member would step into the core work group. The second group included the team members (also the core work group members) and the nursing students. The students were added to the team in five consecutive periods, with each group completing a 20-week internship. In group sessions led by the facilitator every Wednesday over 2.5 years, the team members and students reflected on their practice, made plans for changing and improving practice, and performed practical research activities. During workdays, they tried out new practices. Some research activities were carried out mainly by the nursing students, partly because they were doing internships, and partly because their bachelor's training made them more familiar with these types of activities. The third group comprised the (para)medical professionals working on the ward, including two physiotherapists, an occupational therapist and six consecutive physicians of which three were elderly care physicians and three were junior doctors. Although they had no formal role in this project, they joined some of the team sessions, when circumstances such as the coronavirus disease 2019 (COVID-19) pandemic allowed, and provided feedback on the

progress of some of the PAR steps. Finally, the fourth external project group consisted of academic experts, managers in geriatric rehabilitation and a patient representative. This group monitored the progress of the PAR on a bimonthly basis.

Patients on the ward were not involved in designing the PAR steps, so they cannot be labelled as PAR participants. Because of their relatively fragile condition, the choice was made not to burden them with these tasks. The regular turnover of the patient population also played a role in this decision, as well as the COVID-19 pandemic that affected their health and the extent to which people could be together in one space. The patients did participate in the action and evaluation phases when new initiatives were tested and evaluated with them.

3.5 | TECHNIQUES, PROCEDURES, DATA COLLECTION AND ANALYSIS

During this PAR, reflection, action and analysis were interconnected and occurred in a non-linear manner. Because the challenge of PAR lies in understanding the subject under study by means of communication,²⁶ a core element was a weekly team meeting in which team members and nursing students discussed working on rehabilitation goals with the patients. Cook²⁷ described this as 'just talking'. The talking can lead to two important aspects of PAR: first, it is 'fundamental to move beyond general conceptualisations of practice to deeper understandings'.^{27(p11)} Second, talking—interaction in which there is trust that contributions will be valued and used appropriately—is key to knowledge development and change and, thus, to effective research.²⁸ Bergold and Thomas²⁶ labelled the above-described method as a 'focus group', where participants are given the opportunity to discuss with each other in a safe setting and to deal with aspects of projects. It is a key instrument in creating a communicative space described by Habermas and is seen as a core principle in PAR.^{29,30}

Different approaches were used during the weekly sessions: in some sessions, theoretical models were used to initiate reflection, while in other sessions clinical cases were discussed and used to reflect on daily practice. In addition, various types of data were gathered prior to, during and after the PAR process, and the results served as input for the sessions. The sessions were also used to share experiences and to reflect on new approaches that were tried. Team members, nursing students and the facilitator brought different knowledge and skills to the table. This approach facilitated the co-construction of relevant solutions. Each session was verbally summarised at the end, and the facilitator took notes. Analysing and validating findings was done in a communicative way to 'enhance ownership'.²⁶ The preliminary conclusions drawn from former sessions were summarised, adding new knowledge and experiences—and thus also triangulating—to continuously deepen, refine and get to the core in an iterative process. The findings were distributed to the team members (whether or not they attended the sessions) in a special newsletter, through flip-over sheets hung on the team room wall, in personal emails and in student presentations. The facilitator

monitored the process in a logbook. Work group members constantly corrected or confirmed the accuracy of the interpretations by, for example, giving feedback on reports written for member checks, and they were also accountable to the external project group and management. Table 2 provides an overview of the data collected in this study.

3.6 | RIGOUR

The rigour of this PAR was ensured based on its dependability, credibility and transferability.³¹ The weekly sessions created a continuous process of knowledge development in which member checking was a standard procedure, and this endeavour enhanced credibility. Extra member checking was done by presenting summary reports to the project group and checking the assumptions with the core work group. Additionally, semi-structured interviews, observations by students and the facilitator, short surveys and charting actions used in the PAR contributed to ‘method triangulation’. The facilitator and first author performed this PAR project under supervision of four tutors. To ensure dependability, peer debriefing and peer review were integral parts of their meetings. In a safe environment, the facilitator was invited to employ a self-critical attitude, considering how her opinions affected the research. Transferability was guaranteed by documenting the PAR process in detail; this endeavour included keeping records of discussions and notes, on any decisions made during the PAR.

3.7 | ETHICAL CONSIDERATIONS

The study was approved by the Medical Ethics Review Committee of VUmc supervising this PhD project (decision number 2019.400). This committee concluded that the Medical Research Involving Human Subjects Act (WMO) did not apply to this study.³² Participation was voluntary, and the work and personal boundaries of the nurses and students were considered (e.g., meetings were scheduled during periods of low patient care demand). Informed consent was obtained from the students and nurses before commencing the data-collection activities that we audio recorded. Following Articles 20, 21 and 22 of the Declaration of Helsinki³³ about the patient’s right to self-determination and the right to make informed decisions regarding participation in research, the patients were informed, asked for consent and given the opportunity to decline participation. Consent was recorded. Note that there are two types of consent: written and verbal. The patients were asked to provide written consent when they completed a survey (e.g., before and after the whiteboard project) or were interviewed (e.g., the interview to evaluate the MTM preparation). The patients were also informed that no personal information would be captured, and that if their experiences were to be reflected in research reports, they would be presented in a generalised form. The patients were asked to provide verbal consent when the team tried out actions. We made this choice for verbal consent because the interventions were within the scope of normal care, without risk and we did not collect personal data.

Table 2. The two participatory action research cycles.

Cycle and phase	Objective	Data collection	Analysis	Documentation (form and by whom)
<i>Cycle 1: preparation of the multidisciplinary team meeting with the patient</i>				
Orientation and diagnosis: February 2020 – June 2020	To explore (how) do we as a nursing team support patient-centredness through goal setting, and whether there are aspects of our work that need to be improved	Method: weekly group sessions with team members and students about their patient-centred goal-setting practice Data: facilitator's notes; flip charts of discussions in sessions	Analysis (summarising preliminary conclusions of previous sessions, adding new knowledge and new experiences – thus also triangulating – to continuously deepen, refine, and get to the core in an iterative process) in weekly group sessions with team members and students	Problem and solution catalogue of aspects that could be improved, prepared by students and facilitator PowerPoint presentation by students of findings Flip chart produced by the facilitator with a summary of orientation and diagnosis phase to inform the entire team Report by the facilitator documenting data collection, analysis, and outcomes
	To explore whether patients have goals, know their goals, and work on their goals	Method: 12 interviews with patients by bachelor nursing students regarding rehabilitation goals Data: students' notes of answers on the printed interview protocol		
Development: September 2020 – January 2021	To describe the current practice in preparing the MTM in order to develop an MTM path	Method: student nurses interviewed team members about their current practice in preparing MTM Data: students' notes Method: student nurses observe team members preparing MTM Data: students' notes	Analysis (summarising preliminary conclusions of previous sessions, adding new knowledge and new experiences – thus also triangulating – to continuously deepen, refine, and get to the core in an iterative process) in weekly group sessions with team members and students	Students' report of interviews, observations and questionnaire findings Poster of the seven-step plan about how to prepare an MTM created by the students Presentation of the seven-step plan about how to prepare an MTM by the students Two newsletters with instructions about how to work with the seven-step plan Assignment about preparing an MTM for next group of students by the facilitator and core work group
	To learn about patients' knowledge about and experiences with MTMs	Method: questionnaire administered to 13 patients by students about patients' knowledge about and experiences with MTMs Data: students' notes		

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Table 2. *[continued]*

Cycle and phase	Objective	Data collection	Analysis	Documentation (form and by whom)
Action: February 2021– June 2021	To try out the seven-step plan	Nurses and students started working with the seven-step plan		
	To involve as many team members as possible in applying the seven-step plan To reflect on added worth of patient involvement	Method: Larger group session with team members (24 March) on patient involvement through preparation of MTM Data: flip charts and facilitator's notes	Analysis (summarising preliminary conclusions of previous sessions, adding new knowledge and new experiences – thus also triangulating – to continuously deepen, refine, and get to the core in an iterative process) in weekly group sessions with team members and students	
Evaluation: February 2021– June 2021	To evaluate experiences with the seven-step plan with core work group members	Method: three interviews with core work group members by the facilitator about testing the seven-step plan Data: interview transcripts	Analysis (summarising preliminary conclusions of previous sessions, adding new knowledge and new experiences – thus also triangulating – to continuously deepen, refine, and get to the core in an iterative process) in weekly group sessions with team members and students Counting the number of preparations in electronic patient records Counting the number of times the patient was reported to be involved based on the electronic patient records	Bar chart PowerPoint by the facilitator Report by the facilitator, nurse, and students Report by the facilitator Instruction on how to prepare MTM

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Table 2. [continued]

Cycle and phase	Objective	Data collection	Analysis	Documentation (form and by whom)
	To provide a quantitative and tangible overview of progress in the use of the seven-step plan	Method: over 12 weeks, team members tracked whether the MTMs were being prepared and, if so, whether the patients were involved Data: quantitative overview		
	To reflect collaboratively on new practice of using seven-step plan	Method: preparatory MTM talks with patients by nurses/ students were observed by facilitator and subsequently evaluated with nurses/ students Data: facilitator’s notes		
	To evaluate the preparatory talks with patients	Method: interviews with eight patients by facilitator about their experiences with MTM preparation Data: facilitator’s notes of answers on the printed interview protocol; facilitator’s notes		
	To evaluate new practice of using seven-step plan with nurses and other members of the multidisciplinary team	Method: group interview about new practice of how nurses prepare MTMs with core work group members, physiotherapist, and physician by facilitator Data: flip charts and transcription		

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Table 2. [continued]

Cycle and phase	Objective	Data collection	Analysis	Documentation (form and by whom)
Cycle 2: involving patients in their rehabilitation process using whiteboards				
Orientation and diagnosis: September 2021–January 2022	To answer the following question: how can the MTM on our ward ensure better patient involvement during the rehabilitation process?	Method: four patient interviews by a bachelor's student about involvement in their rehabilitation process Data: interview transcripts	Analysis of interviews by the bachelor's student	Bachelor's thesis PowerPoint presentation by the student
Development: February 2022–June 2022	To discuss and plan whiteboard project approach	Method: core work group session about the whiteboard project approach Data: transcription		Project plan for whiteboard project
	To assess patients' knowledge about their exercise goals	Method: survey / measurement 1 amongst all 20 patients on the ward Data: survey results	Analysis (summarising preliminary conclusions of previous sessions, adding new knowledge and new experiences – thus also triangulating – to continuously deepen, refine, and get to the core in an iterative process) in weekly group sessions with team members and students	Students' report Instruction written by students on how to fill in the chosen whiteboard setup
	To choose a white board setup	Method: two possible whiteboard setups were presented Data: the team members indicated their preference on a shared form	Counting preferences	

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Table 2. [continued]

Cycle and phase	Objective	Data collection	Analysis	Documentation (form and by whom)
Action: February 2022– June 2022	To try out the process of negotiating about goals and writing them on the whiteboards in patients' rooms with eight patients	Method: experimenting with writing goals on the whiteboards in patients' rooms with eight patients Data: notes from students and team members		
Evaluation: February 2022– June 2022	To learn about the added value of writing goals on the whiteboards in patients' rooms	Method: weekly team sessions with team members and students (focus groups) about their experiences in working with goals on the whiteboard in the patients' room Data: facilitator's notes; flip charts of discussions in sessions; pictures of whiteboards	Analysis (summarising preliminary conclusions of previous sessions, adding new knowledge and new experiences – thus also triangulating – to continuously deepen, refine, and get to the core in an iterative process) in weekly group sessions with team members and students	Students' reports PowerPoint by students
	Second inventory of patients' knowledge about their exercise 2: all 20 patients on the ward were asked whether they knew goals	Method: survey/ measurement Data: survey results		
Abbreviation: MTM, multidisciplinary team meeting				

4 | FINDINGS: THE TWO PAR CYCLES

4.1 | CYCLE 1: PREPARATION OF THE MTM WITH THE PATIENT

4.1.1 | ORIENTATION AND DIAGNOSIS: SUBOPTIMAL CONTINUITY OF CARE

Four months were devoted to creating a safe space for exchanging experiences and knowledge about the core subject of the PAR: (How) do we as a nursing team support patient-centredness through goal setting, and are there any aspects of our work in this field that need improving? The result was a problem and solution ‘catalogue’,³⁴ listing barriers and facilitators in this process of working with rehabilitation goals to enhance a patient-centred process. The team found that a fair share of the patients on their ward were not actively engaged in their rehabilitation process. The patients assumed that they ‘were rehabilitated’. The team realised that some preconditions for working with goals were not met, which negatively affected patient engagement in the rehabilitation process. First, one of the problems in the catalogue was the patients’ limited perception of what rehabilitation entails and what is expected from them in it:

In today’s session we discussed the fact that patients in hospital are told: ‘You’ll be going to the nursing home for a short time in order to gain strength before going home.’ The patients think that ‘gaining strength’ means resting. So, we discussed exactly what we should say to patients to explain what revalidation involves. (Facilitator’s logbook. Cycle 1, phase: orientation)

Another item in the problem catalogue was a lack of continuity of care. The team stated that a more consistent approach by all nurses towards patients concerning their rehabilitation goals was needed. This would enhance clarity for the patients and support patient engagement.

Subsequently, the problem and solution catalogue was presented by the nursing students in a special meeting with as many team members present as possible. By applying stickers to their preferred solution, the team chose to focus on the two preconditions for working with goals. Through better preparation of the MTM with the patient, in which they would discuss progress on rehabilitation goals, they aimed to better inform and involve patients in their rehabilitation process. Simultaneously, updating the goals in the patient record was intended to enhance continuity of care. Consequently, all professionals involved would adopt a consistent approach, providing patients with greater clarity about the rehabilitation process.

4.1.2 | DEVELOPMENT: WHOSE CONTINUITY IS PARAMOUNT?

The next group of nursing students set out to develop a working procedure for the preparation of the multidisciplinary care plan meeting with the patient. They interviewed team members about their current practice. For example:

Student nurse: Why do you consider it important to prepare the MTM with the patient? Nurse: By sitting down together, you are more informed about the patient's treatment plan. (Student report, by student nurses 2, 8, and 9, on preparing the MTM. Autumn 2020)

They also observed colleagues, studied the literature about patient involvement in MTMs, and interviewed patients about their experiences. In team sessions, theory about and practice of patient involvement were discussed. One of the findings described in the students' report included:

It was notable that involving the patient in the preparation of an MTM is not mentioned right away. When questioned further, several answers emerged: one person indicated that you can observe a lot during ADLs [activities of daily living] and discuss this with the patient. You then ask the patient how they experience this, taking into account the goals being worked on. You observe this well. Another nurse said that they print out the rehabilitation plan and take it to the patient [...] to evaluate how much progress there is in achieving the goals. (Student report, by student nurses 2, 8, and 9, on preparing the MTM. Autumn 2020)

Based on the interviews, the observations and the literature, the students constructed a seven-step plan on how best to prepare the MTM with the patient (see Figure 1).

Preparing the Multidisciplinary Team Meeting		
1	Check which patients will be discussed in the next MTM.	Preparation by the nurse
2	Study a number of reports of the patient, so as to form an idea of the patient's progress.	
3	Update the progress on rehabilitation goals if necessary.	
4	Write a summary in the electronic patient record on the progress on each goal.	Preparation with the patient
5	If possible, provide care to the patient shortly before the MTM, in order to make your report more accurate.	
6	Inform the patient about the upcoming MTM, ask for their opinion on their progress: do they have any additions to your input? Ask about: Activities of daily living, pain, mobility, mood.	
7	Incorporate the patient's information in your report.	

Figure 1. Seven-step plan on how to prepare the multidisciplinary team meeting.

4.1.3 | ACTION: THE TYPE OF QUESTIONS MUST BE TAILORED TO THE PATIENT'S SITUATION

A seven-step plan was presented to the team, posters showing the steps were hung up in the ward, and in several sessions, the steps were introduced to and discussed with the team members. Everyone started working with the seven-step plan. A new group of nursing students arrived on the ward, and the team members introduced them to the new procedure.

4.1.4 | EVALUATION

Two criteria were identified prior to the evaluation. First, the MTM should be prepared with the patient according to the seven-step plan. Second, in the electronic patient record a report should be written clarifying how the patient felt about their progress. Over the course of 12 weeks, the nurses tracked whether the MTMs were prepared and if they were prepared with the patients. More than half (55%) of the MTMs were prepared by a nurse per the preparatory report (n=78). Somewhat less than a quarter (22%) were prepared with the patient. Three reasons were given for not involving the patient in the preparation: cognitive impairment, language barrier and time. In addition to the quantitative tracking, several other methods were applied to evaluate the preparation of the MTM with the patient (see Table 2).

Several lessons were learned. These lessons could be grouped under three themes: patients' experiences with MTM preparation, preparing the MTM provides useful information about the patient's process, and lack of clarity about responsibilities among nurses.

4.1.4.1 | PATIENTS' EXPERIENCES WITH MTM PREPARATION: THE ADDED VALUE OF MTM PREPARATION WAS NOT ALWAYS CLEAR

With eight patients, the preparatory talks were evaluated in the same week. The talks did not seem to result in the patients gaining a comprehensive understanding of their rehabilitation trajectory. The nursing team had expected this understanding to enhance patient involvement. Four patients did not quite remember the talks. Four patients experienced the preparatory talks positively as a form of attention or it boosted their trust in the team of clinicians to know that they were concerned with their progress:

We [facilitator and student nurse 1, author AMV] realised that although not all patients are able to oversee the whole trajectory, they should nevertheless be informed about what is discussed in the multidisciplinary team meeting. We approached a female patient to inform her of the multidisciplinary team's concerns. She was relieved to hear that these were the same worries she had herself. (Facilitator's logbook. Cycle 1, phase: evaluation)

The patients were not fully aware of the main purpose of the interviews, specifically to hear their views on their rehabilitation progress so that their concerns could be addressed by the nurse in the MTM, thus promoting a patient-centred rehabilitation process. According to the nurses, there were several reasons for this lack of awareness. First, not all patients were familiar with this active role, due to their previous hospital stay, in which they were not expected or able to play an active role. Second, some were cognitively not able to understand rehabilitation as a process due to tiredness or the impact of a disease. Finally, in the nurse–patient dynamics, the patients seemed more inclined to help the nurse gather their information than putting forward their own specific worries.

Even though it became clear that the conversations did not obviously contribute to enhanced patient involvement, the nurses wanted to proceed with working via the seven-step plan. They emphasised the indisputable importance of talking with the patient about steps to be taken towards discharge:

Student nurse 2 described a patient who reacted negatively to the preparatory meeting. He indicated that he thought it was 'useless' and that he had already discussed everything with the doctor. [...] Afterwards it turned out that he was very concerned about the functioning of his pacemaker and had no room in his head to focus on (other aspects of) his rehabilitation. What we took away from this as an important lesson is that a 'negative experience' with a patient when it comes to preparing the MTM should not stop you from persevering. It may well be that the patient also has to grow into this way of working—to get used to it. (Facilitator's logbook. Cycle 1, phase: action)

4.1.4.2 | PREPARING THE MTM PROVIDES NURSES WITH USEFUL INFORMATION ABOUT EACH PATIENT'S PROCESS

During this PAR, the nurses experienced the added value of MTM preparation with the patient. First, it allowed them to optimally represent the patient in the meeting:

Nurse 2 said about preparing the MTM (my representation of her words): Previously in the MTM I could only properly determine the state of affairs for my own patients. I tried quickly to determine the status of the other patients from the reports, but I was hoping, rather than knowing, that I was doing it right (makes a doubtful face). Now, with my colleague's preparation, I am much more confident. I know someone took a good look at it. I can rely on my colleague's reporting. (Facilitator's logbook. Cycle 1, phase: action)

Second, because time was spent with the patient to more thoroughly discuss progress, certain issues were raised that otherwise would not have come up:

Student nurse 6 delves deeper into how to build up intake through the mouth. She read in the patient's record that the speech therapist gave permission to introduce soft foods gradually. She asks why the patient is taking only the nutritional drink. The patient replies that she tried mashed potatoes, but they gave her terrible stomach problems; now the patient wonders how she should approach the introduction of solid food. [...] Student nurse 6 asks if the speech therapist gave her any tips. [...] The patient then indicates that it is not so much a speech therapy problem but more of a dietary problem; swallowing is fine, but the stomach has become unaccustomed to solid food. The result of this conversation is that student nurse 6 consults the dietitian again. (Facilitator's logbook. Cycle 2, phase: action)

In general, non-nurse workers noticed a greater and more valuable contribution in the MTM from the attending nurses.

4.1.5 | LACK OF CLARITY ABOUT RESPONSIBILITIES AMONG NURSES

During this PAR, it also became clear that the nurses felt a certain apprehensiveness in trusting their assessment of the patients' situations. For example, they hesitated putting a patient on the consultation agenda as well as adding patient goals to or removing redundant goals from patients' records. They left this task the physician. The nurses had to be convinced that their attention was expected to help make progress on all the goals, not only on the nursing goals focused on activities of daily living; therefore, the nursing team should be aware of goals the physiotherapist and other health professionals work on with the patient. The same applied to mental aspects of rehabilitation: in their preparatory talk with the patient, experienced nurses also focused on the mental aspects of the rehabilitation process such as motivation and cognition. In cases where these aspects were missing in the plan, some of the nurses did not address them. The important role of the electronic patient record as a supporting tool in the process of preparing the MTM became clear.

4.2 | CYCLE 2: GOALS ON WHITEBOARD IN PATIENT'S ROOM

4.2.1 | ORIENTATION: USE OF WHITEBOARDS MIGHT ENHANCE PATIENT INVOLVEMENT

After the first cycle, the team concluded that the preparatory MTM talks had not resulted in the patient being more engaged in their rehabilitation process. As a next step, the core work group asked one of the students on the ward to focus on the following question for her bachelor's thesis: how can the multidisciplinary team on our ward ensure better patient involvement in achieving their rehabilitation goals? Based on interviews and a brief literature review, her recommendations were: the use of whiteboards in the patients' room to list small exercise goals; working with smaller attainable goals instead of end goals; a weekly evaluation talk; and working with a primary nurse approach, assigning nurses to specific patients. The core work group chose the use of whiteboards in patient rooms to set small goals and to evaluate these regularly as the next step in this PAR aimed at improving patient involvement through goal setting.

The nurses and students, inspired by a research article by Revello and Fields³⁵ on working with goals on whiteboards, together surveyed the patients regarding whether they could articulate their exercise goals, with whom they exercised, and if the whiteboard was already in use for the purpose of goals. Additionally, they paid a visit to a neighbouring ward to learn about their practices with whiteboards.

Table 3. Whiteboard goals and lessons learned.

Reason for patient's admission	Goal(s) on whiteboard	How did the goal come about?	What lessons did we learn?	Quotes for illustration
Patient first in maintenance phase during chemotherapy, then in rehabilitation phase.	Write down what I ate. Write down the questions I have, as well as the answers! Today I am going to make my bed and join the others for one meal in the dining room. Tidy the desk.	The goals related to the "chemo brain" came about largely through conversations between the patient and nurse. Goals relating to energy management were established during discussions between the patient and nurse after the nurse had consulted the occupational therapist.	A whiteboard can be useful in cases of forgetfulness resulting from a "chemo brain". Looking for a connection with personal goals can help a patient remember goals. The patient is afraid of being overloaded; the goals on the board should not give her the feeling that she has to do a lot. Limited exercise tolerance (energy management) is a good topic for the whiteboard. However, the nursing staffs' knowledge is not specific enough to discuss this with the patient and set appropriate goals – consultation with an occupational therapist is thus necessary. Goals can work as a lower limit. The patient does more than is stated on the board, trying to do two rounds more than the five on the board.	<i>After every chemo treatment I'm in a haze, so I write down as much as possible</i> (Patient's quote in student nurse report). <i>Observation: I noticed that the patient was very motivated to do more once she had reached her goal of five laps. She probably thought that an extra lap or two wouldn't hurt since the first five went easily. However, she did not take into account that her current condition does not allow her to walk 10 laps without a walker. She overlooked this fact, or simply did not think about it. Afterwards she said herself that it was too much, but that she really wanted to prove herself</i> (Student nurse report).
Patient in oncological treatment process.	Climb the stairs every day.	The goal was drawn up with a physiotherapist.	This patient is well aware that she has to climb stairs every day, but she appreciates the attention and encouragement involved in filling out and adjusting the whiteboard together.	

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Table 3. [continued]

Reason for patient's admission	Goal(s) on whiteboard	How did the goal come about?	What lessons did we learn?	Quotes for illustration
Patient rehabilitating after new hip and stroke.	Advice: You may put your full weight on your leg. You may bend your leg at least 90 degrees. You may walk around in your room with one elbow crutch. Things to practice Right hand: pay attention to how you hold it! 5 minutes of ball squeezing – after breakfast, after lunch, after dinner.	The physiotherapist had given exercise instructions, and the nurse wrote these on the whiteboard in simple language.	The patient likes structure in the day. The assignments on the whiteboard provide this. The patient needs clarity. Numerical instructions appeal to him. The whiteboard was too full for the patient and the language unclear. The text was shortened and the language simplified.	<i>This gentleman has a great need for structure and clarity. For that reason, we considerably reduced the text on the whiteboard and made certain things more concrete for him (Facilitator's logbook, Cycle 2, phase: action).</i>
Patient in post-urosepsis rehabilitation.	A timetable lists the times the patient must empty his bladder by opening the valve of the catheter.	The goal came about because the patient wanted more independence. He wanted to get rid of the catheter. The doctor suggested working with a valve. The nurse came up with an interim solution: The patient was allowed to empty the bladder himself via the valve.	The patient finds it annoying to be constantly reminded of things due to social anxiety. He prefers to have as few contact moments as possible. He likes the timetable on the board and follows it – it gives him independence. The patient is not ashamed of the goals on the board.	<i>I drew up the goals with a nursing colleague. In the protocol on using the catheter valve we saw that the bladder had to be emptied every 3 to 4 hours. [...] With this information, my colleague and I filled in the board. The gentleman was happy that this information was on the board and was motivated to achieve this goal because he wanted to be free from his catheter as soon as possible (Student nurse report).</i>
Patient rehabilitating after stroke and wrist fracture.	On Thursday you will take a shower.	After having discussed the need for personal hygiene, the patient agreed to have a shower the next day. Because of his ambivalence regarding water and soap, the nurse wrote the agreement to shower on the whiteboard.	The agreement on the whiteboard works like a “big stick”, (it's actually going to happen!). The whiteboard makes the agreement concrete, and the patient has all day to get used to the idea.	

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Table 3. [continued]

Reason for patient's admission	Goal(s) on whiteboard	How did the goal come about?	What lessons did we learn?	Quotes for illustration
Patient rehabilitating after total hip replacement, with the residual symptoms of a stroke.	I am going to work with clay to improve mobility in my hands. At 19:00 hrs I will cycle to improve mobility in my arms and legs.	The patient received assignments from the physiotherapist and wanted these to be put on the whiteboard.	The patient sticks to the agreements that have been made because he needs structure in his day. The patient needs challenging goals. For him, goals should be framed in maximum terms.	<i>If it says 3 minutes, I won't do a minute more (Patient interview).</i>
Patient rehabilitating after cellulitis and possible stroke.	Squeeze pillow with my hand. Walk 2–3 metres using walker for transfer. Get changed while in bed.	The goals were established during a conversation between the patient and a physiotherapist.	The patient made a lot of progress with rehabilitation, but progress has slowed down now. It could be that updating the goal on the board more often would improve motivation. Goals must be meaningful for the patient. Daily reports are provided on how the patient's transfers are progressing. The functioning of the hand is less well reported. Patient is not ashamed of goals on the board.	<i>I need to learn how to tie knots. But I don't have a boat – why do I have to learn how to tie knots? I would like to go to the market independently again, have drinks with my friends. I would like to walk again, get in the car or a bus (Patient interview). Being changed in bed – I don't have a problem with this being on the whiteboard; I'm not ashamed of it. But I can also just let the nurses know myself, when it is needed (Patient interview).</i>
Patient rehabilitating after a cerebral infarction.	Practice pronouncing sounds twice a day. Rest for 60 minutes after lunch.	The patient received assignments from the speech therapist. The patient has a regular habit of resting after lunch when she is at home. To remind the nurse of this, she would like it written on the whiteboard.	Talking about the goals and giving compliments about them helps the patient continue practicing. It was educational for the nurses to discuss with the patient what they would put on the whiteboard – they discovered that the patient has speech therapy exercises and also what problems she experiences. Nursing can now report on this better. The whiteboard is informative for the daughters.	<i>The patient herself sees progress in pronouncing sounds. She likes it when she receives compliments and her efforts are recognized. This makes her want to practice more frequently (Student nurse report). I have reported on this goal several times. The patient always practices on the days that I am there. However, I do not always see my colleagues' evaluations of this goal, so I do not have insight into whether she actually practices every day (Student nurse report).</i>

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Table 3. [continued]

Reason for patient's admission	Goal(s) on whiteboard	How did the goal come about?	What lessons did we learn?	Quotes for illustration
Patient rehabilitating after left cerebral infarction.	Rest 60 minutes after an activity like therapy.	The patient's family indicated that she is tired, and the patient confirmed this. The physiotherapist and nurse agreed for her to take rest periods throughout the day.	In addition to the rest goal, the nurse formulated a goal about paying attention to the left arm. The patient thought this was too much for the whiteboard and gave priority to the fatigue. The board should not become too full. We learned from this that the responsibility for paying attention to this point lies more with the nursing staff; also, that the whiteboard can be an instrument for shifting more control to the patient. The patient forgot about the whiteboard and still needs to be reminded orally to rest. The rest goal on the whiteboard serves as a reminder for colleagues.	<i>We (student nurse 4, student nurse 7, nurse 4) discussed a patient about whom student nurse 7 had filled the whiteboard. This patient has two issues: a lack of energy/fatigue and the attention paid to her left arm. We looked at how the whiteboard corresponds with the rehabilitation plan in the electronic patient record (ECD); the whiteboard is not intended to become an additional 'plan'/instrument, alongside the ECD. It was a very good search that we carried out together. Everyone studies the electric patient record, and we looked at where and how we could include the energy issue in her rehabilitation plan. We decided it could be included as an evaluation with the mobility goal and also in the report as an important observation (fatigue after therapy) (Facilitator's logbook, Cycle 2, phase: action) The whiteboard is of no use to the patient. I don't see any progress towards the goal. The patient only rests when the nurse tells her to (Student nurse report).</i>

4.2.2 | DIAGNOSIS: MOST PATIENTS WERE AWARE OF THEIR EXERCISE GOALS

The survey showed that most patients on the ward could describe their exercise goals. However, the team still wanted to experiment with writing these goals on the whiteboards. They believed this approach could strengthen the nursing team's role in supporting patients to actively engage in their rehabilitation process and exercise.

4.2.3 | DEVELOPMENT AND ACTION: CLARITY IN WHITEBOARD COMMUNICATION

First, the team brainstormed to determine which headings to put on the whiteboard; examples were sought from neighbouring wards, and patients were invited to chip in with their preferred headings. Two possible whiteboard setups were developed, and all team members were invited to voice their opinion. Eventually, one was chosen, mainly because of its clarity.

Next, exercise goals were written on a whiteboard in the patient's room. Flyers were put up in the room to inform all colleagues. The inclusion criteria for the patients were: they were able to understand Dutch and motivated to participate, and the nurse saw opportunities for progress. This email from one of the nurses describes her attempt to set up goals together with the patient:

I asked the patient how he thought his rehabilitation was going. [...] His answer: I can move a bit more than I could. When I then asked what else he would like, his answer came quickly and clearly: I want to be able to walk. I asked him: [...] What do you need to be able to do this? He said that he felt 'bad' that he could not stand on the bridge. He said he had no strength. I asked: Where is there no strength—arms or legs? It took a while for him to answer, but he realized it was his arms. I explained that I wanted to write a small goal on the whiteboard in his room and that his goal for the day would be to practice. Then I gave him weights to practice with. He seemed to agree with this and be happy with it. (Email from nurse 2, January 2022)

4.2.4 | EVALUATION

The whiteboard pilot study was carried out with nine patients. In the weekly meetings, the nurses and nursing students shared their experiences. There were two guiding questions: *how did you collaborate with the patient in establishing the goals on the whiteboard, and were other healthcare professionals involved? How did the patients experience working with the whiteboard goals?* Table 3 gives an overview of the goals on the whiteboards and the lessons learned.

4.2.4.1 | WHITEBOARD GOAL SETTING CONTRIBUTED POSITIVELY TO THE REHABILITATION PROCESS

With eight of the nine patients, working with the whiteboard goals somehow made a positive contribution to their involvement in their rehabilitation process. About half of the goals on the whiteboard came about through a prescription from another healthcare

provider (i.e., physiotherapist and speech therapist); the other half of the goals came about through nurse–patient collaboration, sometimes requiring a consultation with another healthcare provider. A form of patient involvement could also be seen in the case of prescribed goals. In one case, the discussion about which goals should be written on the whiteboard revealed an important insight. The patient prioritised the goal she felt capable of working on independently, asking the nursing team to take responsibility for the other goal. The lesson here was that the whiteboard could function as an instrument to literally give and take responsibility. There were several other lessons the nursing team learned: the whiteboard lent itself to all kinds of topics, not only physical exercises; clarity was important—the whiteboard should not contain too many messages (too many goals could overwhelm and prevent the patient from taking action) and no jargon; a connection between exercise goals and the patient’s personal life was desirable; and patients did not seem to mind goals about personal hygiene written on the board.

4.2.4.2 | THE IMPACT OF GOALS ON THE WHITEBOARD ON PATIENTS’ BEHAVIOUR DIFFERED

The nursing team also learned lessons about the actual impact of the goals on the whiteboard on patients’ behaviour. Setting goals on the whiteboard influenced their involvement in their rehabilitation process in different ways. For three patients, the goals on the whiteboard provided them with the structure they needed during the day; it helped them gain independence. Personal character influenced the way goals on the whiteboard were interpreted: as an ultimate goal or as a minimum level to reach; the personal attention that came with talking about their whiteboard goals with the nurse could enhance motivation, even though some patients knew pretty well what to exercise; and when goals were adjusted less often because progress stabilised, motivation could be affected in a negative way. Finally, the whiteboard also served to inform family members.

4.2.4.3 | WHITEBOARD GOAL SETTING LED TO NURSES GAINING BROADER REHABILITATION EXPERTISE

Finally, a lesson was learned about continuity of care in the multidisciplinary team. Up until this project, the nurses mainly reported on progress in activities of daily living and mobility. Other issues were primarily the concern of the therapist and the patient, and received less attention from the nurse. However, the whiteboard helped the nurse to play a broader role and to integrate these goals into their work:

Speech therapy exercises and moments for rest are posted on the whiteboard. [...] It was very useful for student nurse 7 to discuss with her what they would put on the whiteboard because the student nurse now knows that she has speech therapy exercises, and that she has problems with them. Student nurse 7 is now able to report on this better. (Report of evaluation interview with patient in room 17, and with student nurse 7)

After the pilot study with the nine patients, an instruction was written, and the team started working according to this instruction.

5 | DISCUSSION

The main aim of this study was to provide insights into how, through goal-setting activities, a nursing team in geriatric rehabilitation could refine their patient-centred strategies. Using PAR, the team tried out and reflected on two working methods for goal setting and achievement. Using these methods, they hoped to enhance engagement in the rehabilitation process, first through talking about goal progress during MTM preparation, and second through shared decision-making on planning smaller daily goals.

5.1 | LESSONS ABOUT ENHANCING PATIENT INVOLVEMENT THROUGH GOAL SETTING

Regarding patient involvement, by discussing goals, two lessons were learned. The first was that although patients valued the MTM preparation positively, these talks did not specifically provide the patient with a comprehensive understanding of their rehabilitation trajectory and thus increase their involvement in achieving their rehabilitation goals. The patient appeared to be a vulnerable person not quite able to participate optimally in talks about the rehabilitation process and its associated goals. Based on this finding, we contemplated the following question: should we stop preparing the MTM with patients? Kristjánsson and Thórarinsdóttir³⁶ warned against 'forced participation' dynamics in their study on constrained engagement of vulnerable adults. They labelled patient participation not based on patients' wishes to participate as 'bad' participation; for example, patients can feel stressed or fatigued and thus not be able to participate. We chose not to stop. Although the patients' vulnerability stood in the way of equal communication about goals, discussion of rehabilitation progress with the patients positively impacted their motivation by making them feel seen and heard. It seems that the patients considered 'being listened to' and 'having reciprocal communication' as crucial for their involvement, a view consistent with the findings reported by Kvæl et al.,³⁷ who pilot tested the 12-item Patient Preference for Patient Participation scale with older patients in intermediate care. Still, to encourage patient involvement in rehabilitation goals, the team experimented with using whiteboards in patient rooms to set and evaluate small goals.

The second lesson the nurses learned was that collaboration on the setting of tangible whiteboard goals can make a positive contribution to the patient's involvement in their goals. Strikingly, this element aimed at supporting goal achievement has not been adequately considered in rehabilitation goalsetting interventions.³⁸ Hence, this way of supporting patients in working on their rehabilitation goals requires more attention. Consistently, Wattel et al.³⁹ designed, evaluated and tested a practical guideline on

goal setting that emphasised the central role of goal talk throughout the rehabilitation process, as this gives the patient control over their own rehabilitation.

The nurses found that the impact of the whiteboard goals on the patients' behaviour differed substantially. The experiences during the PAR revealed diverse patient identities (see Table 3, column 4), and each of these identities had different implications for the collaboration with the patient on the setting of whiteboard goals. This did not seem solely related to the phase of their rehabilitation: as suggested by Tijssen et al.,^{11,12} it also depended on the patient's personality. While the whiteboard goals provided some patients with structure and reminders, others mainly appreciated the attention and the motivational power that came with the collaborative goal setting. Some patients gained independence in following their exercise programme, whereas others indicated they still needed the oral encouragement of the nurses.

In summary, while conventional empowerment models in healthcare consider patient involvement to be a central and self-evident condition, we learned that these models can overlook the complexity of patient involvement in practice. Involvement is not a 'one-size-fits-all' concept. Rather, it is highly individual and varies according to each person's health, worries, context, values and character, among other characteristics. Because of these personal differences, the primary role of the healthcare professional is to be responsive to the patient's needs, values and preferences with respect to the content of encounters, the style of communication and involvement in decision-making.⁴⁰ In a previous study, this delicate process of estimating the amount of control a patient is able to wield in the goal-setting process and tuning in on that level of control came about as an important aspect of geriatric rehabilitation nursing.⁴¹

5.2 | LESSONS ABOUT THE ROLE OF THE GERIATRIC REHABILITATION NURSE

The PAR approach provided room for reflection and shared learning. Knowledge about enhancing patient participation was not the only outcome from this PAR. Our findings are similar to those reported by Steensgaard et al.⁴²: nurses began noticing unclear or inefficient work procedures and learned several lessons about the role of the geriatric rehabilitation nurse. First, preparing the MTM can provide nurses with useful information about a patient's progress. Kočo et al.⁴³ confirmed the positive effect of an improved preparation of cases on the quality of discussions and the decision-making process. It strengthens the nurse in their role as patient advocate during the MTM; the preparation helped nurses better to understand the patients' aspirations (and their barriers) and thus enhanced patient-centred care. The second lesson was that a barrier to optimally fulfil this advocacy role was the lack of clarity among nurses about responsibilities. Doornebosch et al.⁴⁴ studied factors that influence interprofessional collaboration in geriatric rehabilitation and found that implicit working processes and unclear policies regarding working methods hindered collaboration and reaching joint objectives.

The third, unexpected lesson emerged while working with the whiteboards. The nurses realized that not all goals had previously been shared by the multidisciplinary rehabilitation team. Having mainly focused on activities of daily living and mobility, the additional communication about whiteboard goals informed the nurses about broader aspects of rehabilitation, such as energy management and speech. Thus, working with the whiteboards helped the nurses gain knowledge that spanned a variety of professional domains, facilitating interprofessional collaboration and enhancing the quality of care.⁴⁵ For the nurse, having this broader knowledge can be seen as a prerequisite for their intermediate role in the rehabilitation team.

5.3 | STRENGTHS AND LIMITATIONS

A specific feature of rehabilitation is the multidisciplinary composition of the team. In this PAR, we did not formally include non-nursing members, and this can be seen as a limitation. This was a deliberate choice because the nursing profession in geriatric rehabilitation in the Netherlands still requires professionalisation.⁴¹ Thus, we focused solely on nurses to give as many nursing team members as possible the ability to participate, and to share and develop their knowledge. Our decision not to include family members was practical: involving family members would have increased the scope of the research, requiring more time, resources and logistical planning. Nevertheless, their role in geriatric rehabilitation is important, and future research should preferably include them.

Conducting PAR on a single ward may limit the generalisability of the findings to other settings, as the characteristics of the ward—in our case, the neurological and oncological patient population—might not reflect those of other wards or institutions. However, in the second cycle of the PAR we found that the goals the patients would like to work on were quite diverse in nature (energy management, speech, mobility, continence, etc.) and served a broad range of purposes (independence, structure, motivation, etc.). Hence, we assume that these results can apply to a broader group of geriatric rehabilitation patients.

Another limitation is that the facilitator experienced a few dilemmas regarding the opportunities available for nursing team members to participate in the PAR. Due to the lack of time earmarked for the nurses to participate in actual research activities, the students in collaboration with the facilitator mainly executed these tasks. Spalding⁴⁶ argued that this 'imbalance' can also be positive: it is a sign of respect for the limited time of the nurses, which leads to more of a coordinator role for the facilitator. However, we presume that a job description allowing nurses to focus on quality improvement, along with an organisational power structure that connects quality management to improvement projects on wards, would generally lead to more sustainable results. Steensgaard et al.⁴² mentioned that similar organisational obstacles influenced the potential of their improved approach concerning goal setting.

Another limitation was the turnover of nursing staff and students due to school schedules, private reasons, as well as the COVID-19 pandemic. This turnover led to discontinuity because ambitious personnel left the ward to work in COVID-19 cohorts. Therefore, it was necessary for the facilitator and the members of the core work group to perform extra activities to keep everyone involved. The work group members acted as ambassadors by discussing the PAR steps with their colleagues during daily work activities. To ensure everyone stayed informed, flip charts summarising individual sessions or specific parts of the PAR process were displayed on the team room wall. At one midterm evaluation, the work group signalled that not every team member was properly engaged. A special newsletter was started for this reason. Back-office information showed that the newsletter was well read.

The facilitator's more dominant role also had the risk of influencing the PAR; due to her background as a former nurse, she saw a more central position of nurses in the multidisciplinary team as a means to enhance patient-centredness through goalsetting activities. By constantly checking her assumptions with the work group and the team, the facilitator tried to minimise this effect. Moreover, her own experiences and predispositions influenced the process because she did not have a note-taker and, in her central position, she constantly translated team members' issues, stories and experiences regarding patient-centred rehabilitation.

Finally, the facilitator experienced a lack of influence due to her external position vis-à-vis the nursing team. This was mainly reflected in keeping agreements on carrying out certain actions, as patient care always takes priority. There were two strategies applied to overcome this barrier: first, to increase the chances of successful uptake of the interventions, she tried to steer the team towards changes that aligned as much as possible with the team members' existing routines. This included contacting the quality officer to find out about organisational policies and adhering to them. Second, to keep the team members involved, she adapted to their fast pace, although this sometimes meant letting go of the researcher's perspective of a thorough research procedure.

The most important strength of this PAR was the significant amount of time spent on learning and doing by the nurses and the nursing students. There were sufficient opportunities for the nurses and students to share their knowledge based on their practical experiences, which contributed to the fun and success of this PAR, and the LIN was crucial to this outcome. Several creative methods were applied during the team sessions to disclose tacit knowledge and to support the nurses and students to explicitly share their experiences. Another strength was our focus on practical implementation and evaluation of interventions aimed at improving patient involvement in achieving their rehabilitation goals. By trying out and evaluating working methods (e.g., whiteboards for goal setting) and involving the patient in the MTM preparation, we gathered valuable insights into the feasibility of these methods. This emphasis on real-world application ensured relevance for clinical practice.

6 | CONCLUSION

This PAR provided insights into how a nursing team through goal-setting interventions can enhance a patient-centred rehabilitation process in which older patients are actively involved. Preparing the MTM with the patient did not lead to the patient developing a comprehensive understanding of their rehabilitation trajectory, nor did it increase their involvement in achieving their rehabilitation goals. However, it did help the nurses understand how the patients experienced their progress and thus enabled the nurses to play an advocacy role in the MTMs. Clarity about responsibilities in the multidisciplinary collaboration, a central feature of geriatric rehabilitation, was found to be a prerequisite for nurses to take on this role adequately. Additionally, the nursing team experienced that working with a more tangible goal-setting instrument like a whiteboard in a patient's room aligned more with patients' abilities and could have a positive effect on an older patient's involvement in the process of rehabilitation. The patients' individual ways of working with the whiteboards gave the nurses deeper insights into the patients' preferences regarding the content of the encounters, the patients' style of communication and the patients' involvement in the rehabilitation process. Overall, working with a whiteboard and letting patients put all kinds of goals on the board allowed the nurses to gain knowledge about a broader variety of professional domains. This helped them to further develop as geriatric rehabilitation nurses and will also contribute to the development of the entire profession in that field.

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APPENDIX 1

Guidelines for Best Practices in the Reporting of Participatory Action Research (PAR) according to Smith et al. (2010).

Guideline	Section we reported in
Plan Ahead for Organizational Structure Adapt conventional organizational headings, or Consider deriving organisational structure from project design elements or emergent themes, or Consider a chronological or narrative framework	A chronological narrative framework was used in section <i>Findings</i> .
Convey the Key Elements of the Project	
How was the project initiated?	See <i>Design</i> section: This PAR was initiated by the nursing professor (XX) in collaboration with the manager of the geriatric rehabilitation unit at the nursing home. They assigned to the team the subject of improving their goal setting practice, considering this a key contributor to patient-centred care.
What was the project's timeframe?	Described in <i>Study setting and period</i> This PAR took place between February 2020 and June 2022.
Who were the participants and/or co-researchers?	Described in subparagraph <i>Researcher</i> and subparagraph <i>Participants</i> .
What was the extent of their participation and the nature of their roles?	Described in subparagraph <i>Researcher</i> and subparagraph <i>Participants</i> .
What was the process within and/or the methodology of the project?	See section <i>Techniques, procedures, data collection, and analysis</i> . See <i>Table 2</i> .
What were the project outcomes and/or emergent actions?	This is described in <i>Findings</i> . The first cycle of action did not enhance patient participation in their rehabilitation process. Therefore the team opted for a second action. This did have a positive effect on patient participation in their rehabilitation process. Additionally the team learned lessons about refining their patient centered strategies.
What comes next (if the project is ongoing)?	Our manuscript does not report beyond the timeframe of this PAR.
Consider charts, timelines, tables, or other graphics to convey part or all of the project design.	See <i>Table 2</i> .
Convey the Experiences of Co-Researchers	

[continued on next page]

Guidelines *[continued]*

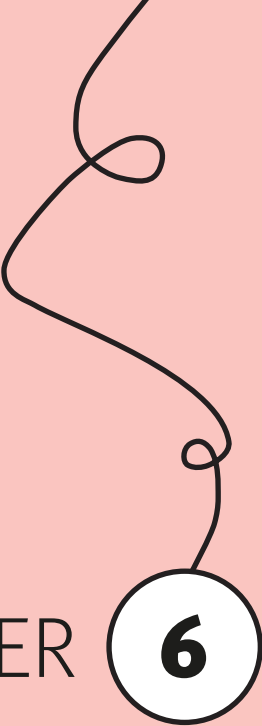
Guideline	Section we reported in
Pay attention to who is writing the article and how their voices and experiences are represented.	In the <i>Discussion</i> section we reflect on the more dominant role of the facilitator.
Pay attention to who is not writing the article and how their voices and experiences are represented	Several citations reflect the experiences of the nurses and nursing students. See section <i>Findings</i> .
What were the personal outcomes of the project?	See section Discussion: Work group members acted as ambassadors by discussing the PAR steps with their colleagues during daily work activities. See <i>Discussion</i> . Lots of time for learning and reflection which was appreciated and which contributed to the fun. Inefficient work procedures were noted. Nurses experienced the positive effect of MTM preparation.
Address the Challenges, Pitfalls, and Limitations of the Project	
What were they?	See <i>Strengths and limitations</i> section: 1. Lack of earmarked time for the nurses for actual research activities. 2. The turnover of staff and students in the nursing team, e.g. due to school schedules, private reasons, and also the covid-pandemic caused discontinuity because ambitious personnel left the ward to work in Covid-cohorts. 3. The facilitator's more dominant role also risked influencing the PAR; due to her background as a former nurse, she saw a more central position of nurses in the multidisciplinary team as a means to enhance patient-centered goal setting.
How were they managed?	See <i>Strengths and limitations</i> section: 1. The students in collaboration with the facilitator mainly executed these. 2. The facilitator and the members of the core workgroup employed extra activities to keep everyone involved. 3. By constantly checking assumptions with the work group and the team, the facilitator tried to minimise this effect.

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Guidelines *[continued]*

Guideline	Section we reported in
What can we learn?	See <i>Discussion</i> section: 1. We presume that a job description that allows for nurses to work on quality improvement, as well as an organisational power structure that connects quality management with improvement projects on wards, in general would lead to more sustainable results. 2. Constant communication about activities and outcomes is important to keep a whole team involved.





CHAPTER

6

INVOLVING NURSES IN PARTICIPATORY ACTION RESEARCH:

FACILITATORS AND BARRIERS

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ABSTRACT

Involving nurses in research and quality improvement is desirable because nurses are often aware of weaknesses in care or organisational processes. In participatory action research (PAR), practitioners are encouraged to identify problems they encounter and, together with the researcher, to develop strategies to solve these problems. The aim of this study was to evaluate the process of involving nurses in PAR, as well as finding out what hampers and/or facilitates collaboration between the nursing team and the researcher and facilitator. Data collected during a 2.5-year PAR with a nursing team (15-18 participants) on a geriatric rehabilitation ward was deductively analysed using seven quality criteria (collaboration, prudent handling of assumptions, accountability, participation, reflection, knowledge sources, and transparency). This study describes how reflection and collective learning as core processes of PAR were facilitated using complementary knowledge sources (theoretical models, knowledge based on practical experiences and results of empirical research collected during the PAR). The study uncovered that providing the time and setting for reflection and collective learning enables a nursing team to be actively involved in PAR: it helps them diagnose their current practice, plan ahead, and critically experiment with actions. Additionally, a positive learning climate is prerequisite for this process. However, without a strong link with quality policy and consequent facilitation of participation through earmarked time, their efforts might not lead to sustainable changes. A more permanent link between PAR initiatives and organisational ambitions regarding quality of care is recommended.

1 | INTRODUCTION

Changes in healthcare practice are often dictated top-down to nursing staff, on the assumption that those at the top of the organisation know what is best.¹ However, involving nurses in research and quality improvement is desirable because nurses are often aware of weaknesses in care or organisational processes.² In participatory action research (PAR), practitioners are encouraged to identify problems they encounter in their daily practice and, together with the researcher, to develop strategies to overcome these problems.³⁻⁵ Several ideas support involving people (e.g., patients, citizens, employees) in research. First, people have the right to have a say in what happens within their context; second, involving participants offers a more diverse set of perspectives which consequently might lead to more practical and relevant results; third, recognising and sharing experiences and expertise enhances collective action, and participation from the outset can prevent the feeling that decisions are being forced upon.^{4,6} In healthcare, involving nurses in quality improvement decreases rigid role boundaries, which may improve staff satisfaction and retention.² Finally, gaining knowledge about their own situations and practices empowers participants.^{4,6,7} According to Migchelbrink⁷, empowerment involves shifting the balance from letting things be determined to self-determination.

1.1 | BACKGROUND

PAR is a subcategory of action research; many researchers consider Kurt Lewin to be its founder.^{3,8,9} The distinctive aspect of action research is that it aims to change practice. It becomes participatory when it strives to bring about change in a democratic way and thus establishes a more equal relation between the researcher and those involved in the situation. To achieve engagement with and between participants of PAR, the so-called communicative space described by Habermas in his theory of communicative action is a core principle.¹⁰⁻¹² Habermas valued lay knowledge and saw people as competent to act on that knowledge.¹⁰ The communicative spaces aim for people to cooperatively interpret and understand their experiences. Communicative spaces “provide an arena in which people’s voices can be heard”.^{10(p15)} Different researchers present the PAR process in different phase models,^{4,5,7,13} but all models work spirally towards a changed or improved situation. Although sketched as a neat spiral, the design of an action research project has, compared to more traditional research designs, a more open and unpredictable character.^{7,12,14} The curly willow with side branches might be a more appropriate way of capturing the PAR process.¹⁴ For example, findings in the orientation phase can lead to reconsideration of the research question.¹⁴ Additionally, changing the current practice, schematically planned for the action phase, can begin in the diagnostic phase because participants become aware of problems.⁷ Available time and resources can also influence the scope and pace of the action cycle; to enhance commitment and motivation, smaller actions with rapid results can be chosen. Therefore, PAR design must be “responsive and adaptive to adjust to the complex and

permanently changing context”.^{14(p27)} The quality of PAR depends on the quality of the participation. This is reflected in Migchelbrink’s⁷ criteria:

- Collaboration: How do the participants and the facilitator cooperate? How are problems solved?
- Prudent handling of assumptions: Have assumptions been checked? How are conflicting viewpoints handled?
- Accountability: Can the researchers substantiate and justify what they want?
- Participation: How is participation facilitated? In what way are participants involved?
- Reflection: Are participants involved in a constant process of interactive reflection?
- Knowledge sources: Have complementary sources of knowledge been used?
- Transparency: Are steps and goals clear for all participants?

This article is about PAR with a nursing team on a geriatric rehabilitation ward of a Dutch nursing home, focused on patient-centered goal setting and achievement. Working and learning as a team in this PAR was intended to improve care and empower the nursing team. The aim of this study is to evaluate the process of involving nurses in PAR and the facilitators and barriers that we observed. Our findings about patient-centered goal setting and achievement are described in chapter 5.

2 | METHODS

2.1 | SETTING AND PARTICIPANTS

This participatory action research took place in a Dutch nursing home, on a geriatric rehabilitation unit. In this unit twenty patients rehabilitate after having experienced a neurological or oncological event. With the support of the multidisciplinary team, they work towards discharge towards their own home. The average length of stay is forty days. In their natural environment, during workdays, the nursing team performed a PAR, following the phases described by Migchelbrink⁷, i.e orientation, diagnosis, development, action, evaluation. The start of the study coincided with the establishment of a Learning and Innovation Network (LIN) on the ward. A LIN is:

“a group of care professionals, students, and an education representative [...]. They constantly reflect and learn from and with each other through a combination of individual and team learning activities. Participants work together on practice-based projects in which they combine best practices, research evidence, and patient perspectives [...] to innovate and improve the quality of care [...]”.^{15(p5)}

The PAR took 2.5 years (February 2000 - June 2022), during which bachelor students were added to the team in five consecutive periods, with each group completing an internship period of twenty weeks. During those 2.5 years, two participatory action cycles were carried out (see Table 1).

Table 1. The two PAR cycles.

Cycle and phase	Activities and outcome
<i>Cycle 1: Preparation of the multidisciplinary team meeting with the patient.</i>	
Orientation February 2020-June 2020	Reflection on: (how) do we as a nursing team support client centered goal setting and which aspect of our work needs improving?
Diagnosis February 2020-June 2020	Outcome of orientation: 1. The continuity of care we provide is sub-optimal, 'we should all work on the same goals'. 2. Patients could be better informed about their rehabilitation path. Diagnosis: the team chose to work on better preparation of the multidisciplinary team meeting with the patient and at the same time updating the patient record to advance continuity of care.
Development September 2020-January 2021	Development of a 7 step plan to prepare the multidisciplinary team meeting with the patient.
Action February 2021-June 2021	Testing the 7 step plan
Evaluation February 2021-June 2021	Evaluation of the 7 step plan and the preparation of the multidisciplinary team meeting with the patient. Outcome: Preparing the multidisciplinary team meeting by providing care, reading previous reports and writing a summary has become a routine. The summary in the electronic patient record needs attention on a few points. To optimally assess the progress with the patient, the rehabilitation plan should be complete, this is not always the case. Involving the patient is not always thought possible because of cognition or language barriers. Starting point for circle 2.
<i>Cycle 2: Involving patients in their rehabilitation process through the use of whiteboards</i>	
Orientation September 2021-January 2022	Bachelor thesis of student answering the question: How can the multidisciplinary team on ward A1 ensure better client involvement during the rehabilitation process? Outcome: Use whiteboard in patient room to set small goals and evaluate daily.
Orientation February 2022-June 2022	Inventory among all 20 patients on the ward whether they are aware of their exercise goals. Working visit to other department to learn about their practice with whiteboards.
Diagnosis February 2022-June 2022	Outcome: a large amount of the patients can sum up their exercise goals. However we want to start working with goals on whiteboards, also for the benefit of continuity between team members.
Development February 2022-June 2022	Development of a whiteboard structure
Action February 2022-June 2022	Experimenting with writing goals on the whiteboard in patients' room
Evaluation February 2022-June 2022	Evaluating experiences with patients. Outcome: there is no one recipe for whiteboard goals. Patients have different needs.

Both the PAR and the LIN were initiated by the nursing professor (RG) and the manager of the geriatric rehabilitation section of the nursing home organisation, assigning to the team the subject of improving patient-centered goal setting and achievement. The underlying goal being to increase patient involvement in the rehabilitation process, making it more patient centered and boosting patient motivation. The nursing team responsible for rehabilitation care included, on average, thirteen employees and three bachelor students (see Table 2). Of the employed staff, an average of six were registered nurses, including the team lead, an average of five were certified nursing assistants, and an average of two were apprenticeship track students seeking to become certified nurse assistants.

Table 2. Nursing team members during the PAR.

Date	Team lead (RN)	Apprenticeship track students in training to become CNA*	CNA*	RN**	Supernumerary bachelor nursing students	Total
Period 1: 1 feb 20	1	2	6	4	3	16
Period 2: 1 sept 20	1	4	4	3	3	15
Period 3: 1 feb 21	1	2	5	5	4	17
Period 4: 1 sept 21	1	2	5	6	4	18
Period 5: 1 feb 22	1	0	6	6	3	16

RN=Registered Nurse

CNA=Certified Nursing Assistant

* Compared to other countries, the Dutch certified nursing assistant education is rather lengthy, namely consisting of a three year practice-oriented course.¹⁶

** Part of the team, but not mentioned in this table, is a group of on average six RNs that mainly work evening, night and weekend shifts, bearing nursing responsibility for the entire nursing home. This group was not actively involved in the PAR.

The nursing team worked closely with (para)medical professionals, such as physiotherapists, occupational therapists, a social worker, a dietitian, and physicians. A lecturer practitioner, who was a former registered nurse (AMV), was assigned to the LIN to facilitate the PAR process. The PAR's core work group consisted of the team lead and two registered nurses. Although rehabilitation pre-eminently takes place in a multidisciplinary team, for two reasons the choice was made to primarily focus on the nursing team. The role of nursing staff in geriatric rehabilitation in the Netherlands is developing.¹⁷ To be able to play an equal role in improving practice in a multidisciplinary setting, participants need time and space with each other on a monodisciplinary level to develop their views and define their role. The (para)medical professionals had no formal role but were involved in several PAR activities, e.g., joining team sessions and giving feedback on the progress of PAR steps. A second more practical reason for not

involving the (para)medical professionals on a more structural base, was the limited number of people allowed to gather together during the Covid-19 pandemic. An external project group, consisting of academic experts, geriatric rehabilitation managers, and a patient representative, was installed to monitor the PAR's progress on a bi-monthly basis.

2.2 | DATA COLLECTION

The data collected between February 2020 and June 2022 included several different types. The facilitator collected fieldnotes in a logbook during the PAR process. These notes describe the collaboration with the work group, team members, and students, as well as the project's progression. Additionally, several conversations with the team or team members (i.e., two team sessions held to decide on important moments in the process; nine semi-structured interviews with work group members, nurses, certified nursing assistants, and students on the team about their experiences; and five evaluative interviews at the end of the two cycles using an image of the research journey) were audio recorded and transcribed. Email correspondence, public accounts written by the facilitator, and newsletters about the project addressed at team members, staff, and managers were also included in the collected data.

2.3 | DATA ANALYSIS

Data were analysed using theoretical thematic content analysis.¹⁸ First, AMV and PB (the researchers) familiarised themselves with the data. Second, the documents were imported into MaxQDA, a software application designed for organising and analysing qualitative data, thus ensuring transparency in the coding decisions and interpretations. We chose a deductive approach because of the evaluative character of the research.⁹ Migchelbrink's⁷ seven criteria for PAR served as a code scheme to work towards a qualitative description⁹ of how the nursing team's participation was facilitated and what barriers occurred. Third, inductive coding was utilised,⁹ searching for barriers and enablers within the coded extracts of the seven criteria. We did this "paper-based," using separate documents per criterion of Migchelbrink.⁷ The researchers discussed barriers and enablers, and AMV reread Migchelbrink⁷ and related literature on participation in PAR to refine the barriers and enablers. A coding tree was developed and discussed with the other authors (EW, CH, RG) and two work group members.

2.4 | RIGOR

The rigor of this PAR is demonstrated through our enhancement of dependability, credibility, and transferability.¹⁹ We strove for dependability through professional peer debriefing and peer review. Part of the data was analysed by the second author. The facilitator and first author, as a PhD student, was supervised by four tutors. With some on a monthly and some on a bi-monthly basis, she shared her entailment in the PAR, thus monitoring through reflexive auditing the influence of her values and passions.

Credibility was achieved through member checking with work group members in each phase of the PAR. Additionally, semi-structured interviews, the researcher's reflexive logbook, and materials like newsletters and flip over charts used in the PAR contributed to method triangulation. We strove to make this research as transferable as possible by providing a rich description. For example, quotations from the data are presented to illustrate the findings. The quotations are coded based on participants' numbers and positions (professional or student). With Green and Thorogood (2018), we note that "the key elements that are generalisable from qualitative research may not be the narrow findings but the concepts, that is the way of thinking about or making sense of the world".^{9(p309)}

2.5 | ETHICAL CONSIDERATIONS

The study was approved by the ethics committee of the university supervising this PhD study (2019.400). Informed consent was obtained before data gathering activities. Participation was voluntary, and the participants' work and personal boundaries were taken into account. Activities were planned with participants to avoid disrupting patient care.

3 | FINDINGS

In this PAR, two cycles were performed (see Table 1). The following section provides a description of the participatory research methods, tools, and processes, using Migchelbrink's⁷ guiding questions. Barriers and enablers that occurred during the PAR are described in Table 3. In this PAR, two types of participants and co-researchers can be distinguished; at the same time, in practice, the tasks of the different groups were intertwined. Firstly a core work group was established consisting of the team lead and two senior team members of the nursing staff. Their share in the PAR and the relation with the facilitator is described under Collaboration. The second group consists of the team members (including the core work group members) and the nursing students. Their role in the PAR and how their contribution was facilitated is described under the criteria Participation, Knowledge sources, Reflection, and Transparency. Finally we describe two more preconditional criteria under Prudent Handling of assumptions, and Accountability.

3.1 | COLLABORATION

In this section the collaboration between the work group members and the facilitator is described. According to Migchelbrink⁷ in PAR the researcher, in the role of facilitator, and the work group members relate to each other in a subject-subject manner, as opposed to research methods in which the researcher has a more neutral observing role towards people as "research objects". "The subject-subject relationship is characterized by equivalence; engaging in a dialogue; and (...) an appropriate division of tasks and responsibilities according to their knowledge, experience and expertise".^{7(pp97-98)} The

PAR's core work group and the facilitator held meetings five times per year on average. In these meetings plans were made, progress and barriers were discussed, and the project steps were evaluated. It was particularly helpful that there were plentiful opportunities to exchange ideas in informal settings, for example during coffee breaks or walking to the bus station. A considerable part of the discussions and decisions occurred in these more impromptu situations. The facilitator had a leading role, presenting ideas to fill in team sessions, summarising session outcomes, and proposing suggestions for next steps in the process. The members of the work group gave their feedback on the facilitator's plans. This quote from the facilitator's logbook illustrates this division of roles:

What could be the next step? I propounded to the work group two focus areas [...] 1. Are we going to involve the patient, yes or no? 2. No specific nursing goals are present in the rehabilitation plan, as we have concluded several times. Which of the two shall we focus on?

They preferred to work on the conversation with the patient, because "ultimately that's what it's all about." (Facilitator's Logbook, Cycle 1, Phase: Evaluation)

The difference in pace between the facilitator and the work group and the nursing team, sometimes caused friction. From the perspective of a researcher, some steps, e.g., jointly defining the goal of an action, called for a more thorough procedure, but the time this required might cause lack of involvement by the team, which mainly consisted of "doers". On the other hand the practical nature of some team members, also was a sign of commitment to the PAR. This is illustrated by an email of a work group member who changed their practice after only one meeting about the plans for a project on writing goals on whiteboards:

Good morning, Just to let you know that I succeeded in formulating small goals for patients. I did it with two patients [...] it took some time and I had to ask the right questions, but it worked. (Email sent 20 January 2022, Cycle 2, by Nurse2, Phase: Orientation)

3.2 | PARTICIPATION

Although it is not always possible to involve all participants present in the PAR setting, Migchelbrink⁷ emphasises the importance of engaging as much members of the community in question, in our case this concerns the nurses and students of the geriatric rehabilitation ward. Weekly group sessions with nurses and student nurses led by the facilitator formed the basis of the PAR. The sessions were held in the team room on the ward, which was equipped with a large table, two whiteboards, and a computer screen on the wall. Pagers were dispensed during sessions, and staff breaks were respected. In these group sessions action research and educational activities

Table 3. Barriers and enablers that occurred during the PAR.

Migchelbrink's criterium	Barriers	Quotes to Barriers
Collaboration: How do the participants and the facilitator cooperate? How are problems solved?	1. Communication: work group members not used to communicating by e-mail or other written means. 2. External position of the facilitator and lacking culture of accountability: fulfillment of commitments partly depends on relationships and trust. 3. Difference in 'pace' between facilitator and the work group and the nursing team (thinkers versus doers).	3. <i>It seemed to me that the team members did not have the patience to listen to what the physiotherapist was telling. They started talking about buying whiteboards, the costs and the (im) possibilities. While I was still brooding on the question: 'will this be of use for our ward? What is useful what is not? [...]. I also had wanted to ask the patient [that was present, AMV] a lot of questions. Facilitator's logbook. Cycle 2, phase: orientation</i>
Participation: How is participation facilitated? In what way are participants involved?	1. Working on quality improvement not being a formal duty of the nursing staff; no earmarked hours for quality improvement tasks. 2. Certain disruptions causing the PAR process to take more time because other matters required attention (refurbishing of the ward and a relocation to another floor, the COVID-19 pandemic etc.). 3. Ambitious personnel leaving the team to work on the COVID unit. 4. General characteristics of nursing work: prioritising patient care over other tasks; shift work; part-time work.	4. <i>Nurse6 [also work group member]: It was hard that I did not have a sparring partner on my side of the ward [...] I work with colleagues who work few hours. Sometimes I find that bothersome for the continuity [of the PAR, AMV]. Final evaluation work group June 2022</i>
Knowledge sources: Have complementary sources of knowledge been used?		

Enablers*	Quotes to Enablers
Breadth of the subject allowing the work group and team to fill the PAR out according to their own needs and affinities. Plentiful possibilities for informal contact between facilitator and working group members. - Facilitator using position of lecturer practitioner to get things done. - Positive energy and practical nature of team members.	<i>As it comes to implementation and securing of improvements in the rehabilitation care, as a teacher from outside I have little ability to influence. What I can do to impact the process, is give the students more or less mandatory assignments. Facilitator's logbook. Cycle 1, phase: action</i>
Student nurses added to the team. The group sessions with team members and student nurses were a central activity of this PAR learning and innovation network. The team lead taking practical measures (time, staffing) to enable team members to work on the PAR. - The team atmosphere facilitating learning and stimulating experimentation. Facilitator's strategy to secure involvement of team members within the limited time: align the overarching theme and activities as much as possible to the needs, routines and fun of the team. - Being locked up in their ward during the Covid-19 pandemic, enhanced team bonding and bonding with facilitator. Working on the PAR distracted from stress caused by Covid-19.	<i>One of the students presented her ideas for her bachelor thesis, the group [four team members and two student nurses] chose self-management. This aligns closely with patient centered goal setting, because stimulating self-management is an important action as it comes to working on goals, [...]. They named three cases of patients who at home perform certain activities independently, but on the ward these activities are taken over from them. [...] it went super well. Everyone contributed, positive atmosphere, constructive thinking with student nurse3, all kinds of problems were mentioned. Facilitator's logbook. Cycle 1, phase: orientation</i> <i>At the start of the next period [...] the question is how to proceed and what is needed. [...] One of the possibilities is to further develop the clinical reasoning, incorporating the rehabilitation goals and increasingly work towards clearer reporting, more patient involvement, this aligns well with need and enjoyment in the team. Facilitators progress report September 2021. Cycle 1, phase: evaluation</i>
- The safe learning climate facilitating the exchange of experiences and stimulating experimentation. Meetings were on the ward, thus making it easy to involve patients in activities. - The facilitator, in her role as lecturer practitioner, having access to theoretical knowledge sources. The exchange between more practically experienced team members and the theoretically schooled students.	<i>Facilitator: What circumstances do you think helped us [in reaching our goals]? Nurse2 [also a work group member]: That it did not matter if I wrote crooked sentences [...]. That helped me, especially with the physiotherapist and the occupational therapist. They didn't mind. Final Evaluation Work Group, June 2022</i> <i>What made me happy was that nurse4 and student nurse4 together set up a board at Room 1. Really great to see how student and staff find each other and work together. Facilitator's Logbook, Cycle 2, Phase: Action</i>

[continued on next page]

Table 3. *[continued]*

Migchelbrink's criterium	Barriers	Quotes to Barriers
Reflection: Are participants involved in a constant process of interactive reflection?	1. The reflection process was mainly being led by the facilitator. Her personal interests and knowledge gaps inevitably steered the team members' process of knowledge growth through reflection in a certain direction. 2. The facilitator, not having a note-taker at her disposal, in her central position, constantly translating team member's issues, stories, and experiences to the subject of patient-centered rehabilitation, thus influencing the process by her own experiences and predispositions.	2. <i>Fancy lively meeting, nice conversations ensued, walking around along flip chart sheets also worked well. The only thing is: I find it difficult to make a good report of such a meeting. I am having a hard time taking notes and at the same time listening carefully.</i> Facilitator's logbook. Cycle 1, phase: action
Transparency: Are steps and goals clear for all participants?	1. All team members had access to an internal information site to read and post messages, but not every team member was used to visiting that site for information. 2. Due to bureaucratic issues, the facilitator not having access to this system for the first 1.5 years of the project. 3. Discontinuity in staff during the PAR due to organisational and personal reasons. 4. Alternating student groups requiring extra efforts to involve them.	3. <i>Because of Covid-19, the client population is becoming more complex. Hospitals are postponing planned operations and only treating the really difficult cases. We currently have many physically and mentally demanding clients in the department, as well as absenteeism. The past few Wednesdays have not been very well attended because of this.</i> Facilitator's logbook. Cycle 2, phase: orientation
Prudent handling of assumptions: Have assumptions been checked? How are conflicting viewpoints handled?	1. The facilitator's wish not to offend the nurses might have caused too much prudence and hampered asking essential questions.	1. <i>But I don't dare email that to her unannounced, because I'm sure she will take that as inadequacy on her part. So I'm going to try to discuss it with her very gently tomorrow.</i> Facilitator's logbook. Cycle 2, phase: orientation

Enablers*	Quotes to Enablers
1. The involvement of other health professionals resulted in more insight in strengths and weaknesses in the team practice, weaknesses the team sometime was not aware of or had accepted as unsolvable. These insights she shared with the work group and some led to new initiatives.	1. <i>Talking to the physician on the ward, she mentioned that the rehabilitation plans are not always up to date [...]. The nursing team should use these plans when preparing the multidisciplinary team meeting. But if they 're not up to date or goals are even missing than evaluating is difficult. Frequently, even goals on washing, dressing and toileting are missing, which you would expect the nursing staff to set up.</i> Facilitator's logbook. Cycle 1, phase: evaluation
1. The work group members functioned as ambassadors towards the other team members for the changes made and involved as many colleagues as possible in the process. 2. Work group members emphasized the importance of keeping all team members involved and deliberated the best ways to do this. 3. During a period of eighteen months, 25 newsletters were sent containing messages about the progress of the project. Back office information showed that the newsletter was well read.	1. <i>Facilitator: But I am hopeful. Nurse1 [also work group member] sets herself up as something of an ambassador for the LIN, she is now convincing Nurse2 [new work group member] how important the preparation of the multidisciplinary team meeting is. I'm really happy with that.</i> Interview with Nurse3 Cycle 1, phase: action
1. The facilitator's awareness of possible power imbalances. Not wanting to impose her opinion on the team, and aware of the authority she may embody as a lecturer practitioner, she kept checking with team members and nursing students how they experienced the change. 2. The facilitator's awareness of her bias.	1. <i>Currently, preparing the multidisciplinary meeting in the electronic patient record is going well [...] The team members are positive about it, too. One of them said: Before, when it came to patients I didn't know, I had to improvise in the multidisciplinary team meeting. This made me feel uncertain: am I giving the right information? Now I can trust what is written in the electronic record, it's an accurate representation of the patient's current situation.</i> Facilitator's logbook. Cycle 1, phase: action 2. <i>Facilitator: One of them [member of the multidisciplinary team] said things like: we shouldn't burden the nurses with that, that's too much administration for them [...] That annoys me, I find it patronising, talking about burdening, it's their job.</i> Facilitator's logbook. Cycle 1, phase: action

[continued on next page]

Table 3. *[continued]*

Migchelbrink's criterium	Barriers	Quotes to Barriers
Accountability: Can the facilitator and work group members substantiate and justify what they want?	1. Work group members not being held accountable by their manager for results. 2. Work group members not of their own accord linking the PAR activities to their organisation's ambitions for quality improvement. 3. Infrequent team meetings with all nursing staff present making it difficult for work group members to share their actions with less involved team members.	3. <i>Following the email Nurse2 wrote to the team about the MTM not going well, there was then a meeting this afternoon. The nurses were poorly represented [...]. It's a mystery to me ... why people don't come, nobody in the ward knew about it either. Although everyone had an invitation by mail.</i> Facilitator's logbook. Cycle 2, phase: diagnosis

*This table contains both enablers (in bold) that are concrete, transferable methods, processes, or techniques which can be applied by other participatory action researchers, and enablers (not in bold) that were specific to this project and less easily replicated.

were intertwined. In the orientation phase, the facilitator, nurses and students got to know each other and collectively reflected on the present practice and context, with the intent of ultimately improving their goal setting and achievement with patients (see also section Reflection). Then, in the diagnostic phase, they collaboratively decided "what is the matter" and, in an ongoing dialogue, discussed and chose possible actions through voting. In the development phase, actions were prepared in a design or plan. Subsequently, in the action phase, changes were implemented and concurrently evaluated. In a new cycle, new actions were performed based on the evaluation; in the evaluation phase, participants also reflected on the process, answering questions like "What have we learned?" and "How did we cooperate?" All in all, the Wednesday sessions became popular during the PAR:

Quote of the day by nurse5: "I really like those sessions on Wednesday! Please email me!" (Facilitator's Logbook, Cycle 1, Phase: Action)

Instrumental to this success was the facilitator's strategy to align the overarching theme and activities as much as possible to the needs, routines and last but not least, the working pleasure of the team.

At the start of the next period [...] the question is how to proceed and what is needed. [...] One of the possibilities is to further develop the clinical reasoning, incorporating the rehabilitation goals and increasingly work towards clearer reporting, more patient involvement, this aligns well with the team's needs and enjoyment. (Facilitator's progress report September 2021. Cycle 1, phase: evaluation)

Enablers*	Quotes to Enablers

Despite the positive experiences, the weak organisational preconditions for involving nurses in quality improvement hindered full participation in all phases of the PAR. For example the nursing staff did not have earmarked hours for quality improvement tasks. This posed the risk of the PAR becoming mainly the students’ project:

While the orientation and diagnosis phase was a collaborative process between team and students, in the development phase it was mainly the students’ turn. Students, because they are doing internships, can claim time to work on improvement projects. So far, it has not been possible to form an “improvement team” that includes employees from the nursing team. (Facilitator’s Logbook, Cycle 1, Phase: Development)

3.3 | KNOWLEDGE SOURCES

This section describes the use of complementary knowledge sources. According to Migchelbrink⁷ three knowledge sources play a role in developing knowledge for action, the ultimate goal of PAR. Both the results of empirical research collected during the PAR as well as participants’ knowledge are needed, and also existing academic knowledge is deployed.^{7(pp117–119)} To start with the final: theoretical models were used as guides to stimulate exchange between team members while reflecting on their practice. Examples include Thompson’s model of patient participation²⁰ and descriptions of patients’ needs concerning goalsetting.²¹ The latter were used to reflect on questions like “When it comes to meeting these needs, which one has priority?” and “As a member of the nursing staff, is it your role to meet this need?” Furthermore, nursing students studied literature on patient involvement in multidisciplinary team meetings (MTM). In the second PAR cycle, a report on research about working with whiteboards was used as an example for a small-scale research project on the ward. During the PAR several forms of empirical research were used. Patients were interviewed about their personal

rehabilitation goals, about their involvement in the rehabilitation process, about the preparational talk prior to the MTM and about their experiences with goals written on a whiteboard. Students observed colleagues while preparing the MTM and interviewed them about their practice. Students and nurses were interviewed both individually and collectively about their experiences preparing the MTM following the new procedure. A digital survey was conducted amongst nurses about their role in the MTM. During a period of 12 weeks the team kept count of the amount of preparatory reports in the electronic patient record and checked whether or not patients were involved. Twice during a period of twenty weeks a survey was held amongst patients asking them about the way they exercised on rehabilitation goals (independently or with help) and how they remembered their exercise goals. Also the whiteboards in the patients rooms were examined for containing exercise objectives or instructions. Finally the knowledge of nurses and students based on their practical experience played an important part in this PAR. Every Wednesday time was spent on reflecting about their work. See section Reflection for a further elaboration of tools used to facilitate this. During the group sessions, the more practically experienced team members and the theoretically schooled students participated equally and often pulled together:

What made me happy was that nurse4 and student nurse4 together set up a board at Room 1. Really great to see how student and staff find each other and work together. (Facilitator's Logbook, Cycle 2, Phase: Action)

Nurses discussed the clinical situation of a patient including the rehabilitation goals set by the multidisciplinary team and reflected on how these goals matched the patient's personal goals. In the two action phases, experiences were shared, and participants reflected on preparation for multidisciplinary team meetings and working with whiteboards. This led to more specific practical knowledge.

Student nurse5 made the observation that through this way of talking with the patient (going through their rehabilitation goals and telling them that they (i.e. their nurse) need to be well informed about the current progress of the patient) [...] the patient, instead of bringing up his own points, helps the nurse to make a good impression in the multidisciplinary team meeting. (Facilitator's Logbook, Cycle 1, Phase: Action)

3.4 | REFLECTION

This paragraph describes how reflection, as a core process of the PAR process, was facilitated. Migchelbrink states that “through collective reflection participants develop new perspectives for action and their abilities to act / competences are strengthened. (...) Reflection can be seen as a vehicle for change”.^{7(p131)} Reflection was a central activity in this PAR. Nursing team members reflected weekly on their practice, and generated new insights and ideas through this collaborative process. To disclose the often tacit

knowledge and help the nurses and students in formulating and sharing their work experiences, several creative methods were applied in the team sessions. With the help of Wisdom quotes (self-invented, quotes derived from Loesje)²² the participants shared their experiences of their current work life on this ward. With the help of animal pictures (self-invented method) the participants explored their role in the multidisciplinary team. Using the Geriatric Quartet Game²³ they investigated what kind of geriatric rehabilitation nurse they are and which aspect of working in geriatric rehabilitation appeals to them. The method Reflection Lense (self-invented method) was used to with the help of several theoretical representations of geriatric rehabilitation issues, compare theory to practice. Through talking about and reflecting on the similarities and differences between theory and practice new ideas about their work and actions emerge. For example, based on theory about what patient characteristics influence their level of participation,²⁰ we explored the question: “Do we recognize these characteristics in our patients?” And “How can we meet the needs of patients with certain characteristics?” With the Fishbone chart or Ishikawa-diagram²⁴ participants mapped the causes of decreasing self-management of patients. The question “How to ensure a patient-centered approach despite shift work?” was reflected on by drawing a Flow chart (self-invented method), thus making sense of joint actions that contribute to continuity of care. Clinical case discussions were used to explore and elaborate on the interconnection between the professional goals and the patient goals, and patients’ understanding of the rehabilitation process. For this purpose we developed a method called Clinical Coffee talk. The method was based on the Situation-Background-Assesment-Recommendation hand off tool. Using the Flip over dialogue method²⁵ a reflection session was held on the experience of preparing the MTM. Each sheet had a different main question (see Figure 1). Participants answered the question, exchanged in their sub group and then switched to the next sheet.

Reflecting on their experiences resulted in personal awareness for the team members and students, e.g., about a preferred way of working, the added value of preparation with the patient, or certain barriers in the conversation with the patient.

We had this really special talk with the extraordinary outcome that some of the nurses are reluctant from their culture to go too deeply into what concerns patients. They do not want to invite people to tell about their dirty laundry. To build a relationship in which patients are willing to share their concerns, some nurses employed the strategy of sharing some personal information. (Facilitator’s Logbook, Cycle 1, Phase: Action)

Through the method Paper Prototyping²⁶ students and nurses made an effort to translate information from the electronic patient record to a whiteboard format on paper. Patients were involved in this process, not in the actual drawing of a prototype but they commented on the results and shared their opinions on usability of the boards.

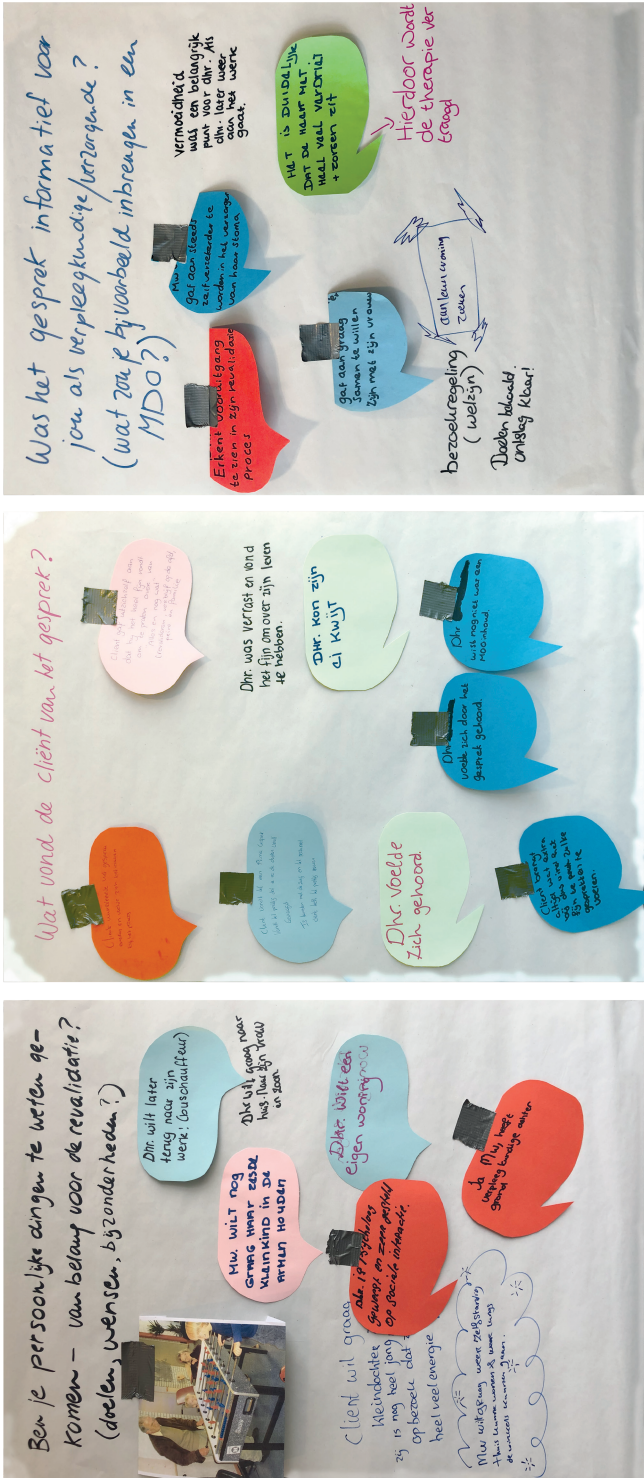


Figure 1. Reflection session held on the experience of preparing the MTM.

Flap 1: What personal information did the patient reveal, relevant for the rehabilitation (e.g. goals, wishes)?; Flap 2: What did the patient think of the interview?; Flap 3: Was the interview useful from a nursing point of view? What will you take away from it to the MTM?

3.5 | TRANSPARENCY

The question Migchelbrink⁷ wants us to answer as it comes to the transparency of the PAR process is: “Are steps and goals clear for all participants?” This is especially important in the light of the empowerment of participants. PAR does not only lead to new behaviour or practice, but also empowers those involved. They gain more control over their situation. This can only happen if the entire process is understandable and “fits within the participants’ horizon”.^{7(p79)} Both the facilitator and the work group members played a role in keeping team members informed and thus helping them to actively participate. Decisions on the action to undertake in both action cycles were taken in group sessions. In the first cycle through voting, in the second through a co-creation session on working with whiteboards. The facilitator acted as a central figure, constantly connecting team member’s stories and experiences to the subject of patient-centered rehabilitation and actively bringing up the subject each week in different ways (see *Knowledge sources* and *Reflection* section). Work group members fulfilled an ambassador’s role by discussing the PAR steps with team members during daily work. Flip over sheets sharing information from single sessions or summarising a part of the PAR were hung on the team room wall to inform those who were absent (see Figure 2).

Nursing students would present their part of the PAR every twenty weeks, at the end of the internship period, and sometime also half way. Over a period of 18 months, 25 newsletters were sent to the nursing team members, the students, the physician, the allied healthcare professionals, the manager, and the quality officer. The newsletters contained updates on the progress of the project, questions to stimulate involvement, etc. Back office information showed that the newsletter was well read and contributed to the transparency. Messages were posted on the internal information site of the organisation.



Figure 2. Flip over sheet from a team discussion on the roles of a geriatric rehabilitation nurse.

3.6 | PRUDENT HANDLING OF ASSUMPTIONS

In PAR all those involved in the research are treated as active participants rather than passive subjects. However, work group members and facilitator are not equal to each other, they bring with them different knowledge, they act from a different position, et cetera.⁷ These differences need not be an obstacle to working together on an equal basis, as long as there is appreciation for what the other thinks, can, does, without judgement. Migchelbrink^{7(p98)} states that dialogue is an important instrument to get to know each other and jointly explore different perspectives. The facilitator repeatedly checked with the work group on the course of the project and asked them to substantiate their points of view, for example on the PAR's underlying goal of increasing patient involvement in the rehabilitation process:

Facilitator: "I spoke with a number of patients [...] and it struck me that they all put their rehabilitation process in your hands and those of the physiotherapist and the doctor. And they do not seem to have a problem with that. That made me wonder: why do we emphasise the importance of patient participation? It made me want to check this again with you". (Group Interview, August 2020, Cycle 1, Phase: Diagnosis-Development)

Some more implicit assumptions or biases became clear in the course of the process and were used to critically reflect on. When team members experienced that allied health care professionals had other assumptions about this role of the nurse, these assumptions were openly discussed with the allied health care professionals and used as cases to reflect on among the nurses:

Student nurse2: "There was a risk of falling. So we thought: it might be wise to discuss this with the patient. But they [allied health care professional] said: 'No, that's our job. You don't have to evaluate on that item'". (Interview with student nurse. Cycle 1, phase: development)

3.7 | ACCOUNTABILITY

Accountability is about being able to explain steps in the PAR process to external stakeholders.⁷ The facilitator mainly took responsibility for this task. Reports on progress were written by the facilitator and in the service of member check, read and commented on by the project group members. The reports were addressed to the manager, the director, the education officer, the quality officer, and the external project group. The facilitator was in regular contact with the quality officer to make sure initiatives on the ward aligned with nursing home regulations. The facilitator also reported obstacles at the nursing home level to the quality officer. The facilitator reported quarterly to the external project group. The work group was mainly focused inwards. Work group members did not of their own accord link the activities to their organisation's ambitions for quality improvement. Additionally, management did not

verbalise their expectations of which targets to strive for to team members. This was discussed in a final evaluation with a quality staff member:

Within our organisation [...] that's often [...] I would not want to call it a shortcoming [...] but a bottleneck. Not only in our organisation [...] by the way, other organisations experience this as well. We expect nurses to participate in project groups in addition to their regular duties. (Final Evaluation with Quality Staff Member, June 2022)

At one specific moment, the work group members felt the need to go public with the results of their project, because nursing staff of other geriatric rehabilitation wards commented on the large amount of personnel on the PAR ward due to the extra student nurses present. To make the results of their actions visible, one work group member created a bar chart showing the number of prepared multidisciplinary meetings, as well as the number that involved patients in the preparations (see Figure 3).

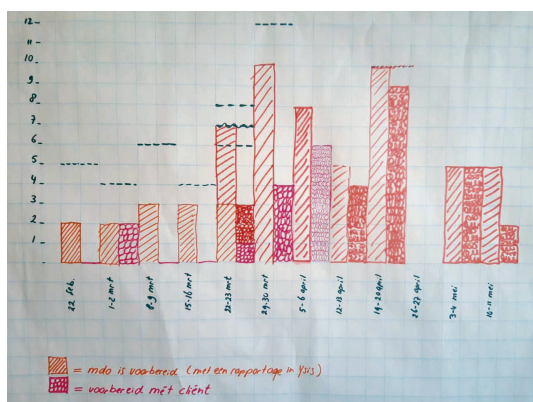


Figure 3. Bar chart showing the number of prepared multidisciplinary meetings (black dotted line: number of patients on MTM agenda; orange bar with stripes: number of prepared MTM meetings; pink bar filled with circles: MTM prepared with patients)

4 | DISCUSSION

The aim of this study was to evaluate the process of involving nurses in this PAR and the enablers and barriers that arose, using Migchelbrink's⁷ seven criteria. The underlying vision was that projects that involve nurses will lead to more appropriate actions and offer them a greater sense of control. Ultimately, the ambition is that PAR projects will enable nurses to increasingly succeed in defining their practice. From this PAR, one important enabling aspect emerges, which is the context in which this PAR took place: a learning and innovation network.¹⁵ This enabler falls under Migchelbrink's⁷ criteria focused on participation, knowledge sources, and reflection. Additionally, one crucial barrier occurred: the weak organisational structure for quality improvement,

which falls under Migchelbrink's⁷ criteria focused on participation and accountability. Finally, some dilemmas arose related to the role of the facilitator. This was particularly evident in relation to the collaboration, participation, reflection, and transparency criteria. This project took place in the context of a learning and innovation network -- in short, a (geriatric rehabilitation) team in which learning together and improving care are core ambitions, enhanced by the addition of student nurses. In the learning and innovation network, reflection was built in as a natural, routine part of the work week; consequently, team members came to value their involvement in the participatory action process. The weekly sessions provided a safe learning climate for exchange and experimentation. The learning and innovation network thus offered the team "a space where people feel comfortable and safe," which, according to Dedding et al.,¹¹ is the starting point of genuine participation. Like Cusack et al.'s¹ participatory research with nurses in a public health practice in Canada, our results suggest that the sessions created a sense of belonging. Team members started to ask to be scheduled on Wednesdays. The learning and innovation network helped establish the so-called communicative space described by Habermas. Habermas' communicative spaces encourage critical reflection and understanding through dialogue, allowing participants to engage in collective reasoning and analysis of issues of their concern.¹¹ In our project, reflecting on practice was a core activity. Nursing practice and patient experiences were appreciated knowledge sources, and reflecting on daily practice in several ways "led to uncovering layers of interpretation and understanding that may not be possible with other research approaches".^{11(p17)} For example, this process led to honest conclusions about aspects of nursing practice that hamper an efficient rehabilitation process for the patient. We prudently assume that our goal to prevent epistemic injustice: ignoring nurses' views because of their position, lower in rank than policy makers, and thus missing crucial information,²⁷ has been achieved. The main barrier we encountered was the weak organisational structure for quality. While there was time on Wednesdays for exchange between team members and experimentation with new actions, time for actual research activities was not earmarked and thus limited; we note that this affected the participation and accountability criteria. The underlying cause of the lack of earmarked time - the limited link between the PAR and overall quality policy of the organisation - deserves attention. We tend to presume that a power structure in which PAR and quality management are connected will lead to more sustainable results. Comparing our project to Cusack et al.'s¹ PAR, in which public health nurses were involved, exposes the added worth of an organisational power structure on quality management involving nurses. In their PAR, a nursing practice council of the organisation functioned as the main structure.¹ A nursing practice council is a formalised structure for staff nurse decision making in operational and professional practice issues.²⁸ Primary participants were members of the practice council; secondary participants were nurses who attended the practice council's meetings and in turn engaged colleagues on their teams. This formalised council and team communication structure ensured high participation.¹ Joseph and Bogue²⁹ state

that organisations with higher levels of shared governance, of which practice councils can be part, show faster uptake of new methods that improve nursing outcomes. Dedding et al.^{11(p7)} argue that if we want participation to become sustainable, it needs to be grounded in the “capillaries of an organisation.” Williamson and Prosser³⁰ claim that when the organisation’s commitment to develop and learn from practice is failing, action research can cause frustration, producing much reflection but little change. Cornish et al.⁸ plead for collaborations that are backed through sustainable staff appointments, formal recognition of the value of research-practice partnerships, and provision of administrative support. Both Dedding et al.¹¹ and Cornish et al.⁸ advocate building bridges, not only to ensure that policymakers and researchers gain an in-depth understanding of people’s needs but also vice versa: grounding participation in the organisations’ influence structure will help participants - in our case, nurses - understand the perspectives of researchers, policy makers, and managers. This mutual understanding establishes a more sustainable relation between research and practice.⁸ Dedding et al.¹¹ argue that to achieve this, policymakers and researchers need to familiarise themselves with more creative and inclusive methods. Shared governance can take many forms and tends to be limited to traditional board governance with some staff input.²⁹ This PAR showed how participation on the ward level can be made enjoyable. As a final point, we highlight the dilemmas the facilitator experienced with influence and power. These dilemmas became apparent in collaboration, participation, reflection, and transparency. The facilitator struggled with a lack of influence because of her external position. She employed three strategies to overcome this. First, she focused on changes that aligned as much as possible with the team members’ existing routines. Bunn et al.³¹ confirm that this increases the chances of successful uptake of an intervention. Second, she adapted to the team members’ pace to keep them involved, a strategy also applied by Spalding³² in her PAR with nurses. Third, she used her influence as a teacher as a catalyst at some stages of the PAR. On the other hand, at some stages, the facilitator experienced more power or influence than she deemed appropriate for PAR, as became apparent under participation, transparency, and reflection. Due to the lack of earmarked time for actual research activities, they were mainly performed by the students in collaboration with the facilitator. Spalding³² argues that equal participation in all phases of PAR is not essential and that an imbalance can be viewed positively: the researcher respects the limited time of the other participants by taking on a more in-depth coordinating role. However, in our project, the facilitator’s more dominant role risked steering the project in a specific direction because of her personal background as a former nurse, striving for a more central position of nurses to enhance patient-centered care. The facilitator tried to minimise this effect by constantly checking her own assumptions with the work group and the team. The results show that the balance between the external facilitator and the internal engaged leaders was suboptimal. According to Buckley et al.,³³ who reported on using PAR to implement guidance in long-term care settings, both parties are key components to successful implementation.

Closing this discussion, we would like to tie together the three main lessons we learned about involving a nursing team in PAR, and recommend further research. The learning and innovation network provided a space for nurses to reflect on their practice. This led them to draw honest conclusions about their nursing practice and self-select solutions. However, there was a feeble link between the PAR and the organisation's overall quality policy, which hampered full involvement and gave the facilitator more power than was desirable. A PAR supported by a shared governance structure might well solve these issues. First, a structure that covers and connects all layers of the organisation and formally arranges participation, democratic decision making, and accountability establishes a substantive and natural link between management's goals and what happens in the wards. Second, it guarantees nurses' involvement and engagement at all stages of PAR. Specifically in the light of the new Dutch legislation³⁴ that gives nurses a say in their organisations' care policies, we recommend research on PAR as a method to shape shared governance and allow nurses to take the role they deserve in improving their practice.

4.1 | STRENGTHS AND LIMITATIONS

The facilitator's logbook was an important data source, used to assess nursing team members' involvement in this PAR. Therefore, findings may reflect the facilitator's predisposition. Deductive analysis carries the risk of losing data that does not fit the predefined categories. However no additional themes were captured, that were not initially accounted for in the deductive framework.

The facilitator was a novice to PAR. An experienced researcher might have been more aware of the importance of involving management and quality staff and would have demanded their commitment to the organisation. The facilitator's experience as a nurse was a strength -- she could easily relate to the the team members' practice. Her being a teacher was a strength, too, as she possessed competencies to enhance reflection and stimulate exchange, through which knowledge growth occurred.

4.2 | CONCLUSION

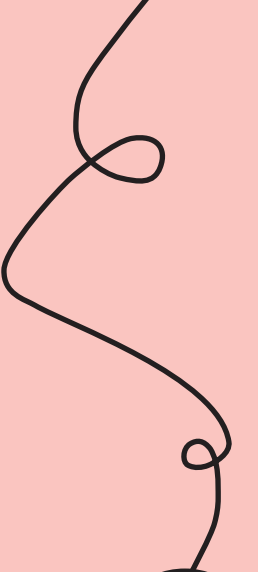
This study uncovered that providing the time and setting for reflection and collective learning enables a nursing team to be actively involved in PAR: it helps them diagnose their current practice, develop strategies, and critically experiment with actions. Additionally, a positive learning climate facilitates this process. However, the lack of a strong link with quality policy and the consequent lack of facilitation of participation through earmarked time served as a barrier. As a result, efforts are less likely to lead to sustainable change. A more permanent link between PAR initiatives and organisational quality ambitions is required.

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CHAPTER

7

GENERAL DISCUSSION



GENERAL DISCUSSION

In the final chapter of this thesis, the main research findings are summarised and reflected upon. The findings lead to implications for education and practice, as well as a proposal for future research. At the end of the chapter, I reflect on the applied research methods and make a case for research that involves nursing in order to improve nursing practice in a robust way.

1 | SUMMARY OF THE FINDINGS

Older people who have experienced a major health event can rehabilitate in a geriatric rehabilitation setting before they return home. Joint goal setting between the patient and healthcare professionals is a method used to help patients work purposefully towards discharge. By aligning professional expertise with the goals, life aspirations and capacity of the person needing rehabilitation, patients' engagement in their rehabilitation process can be promoted. This thesis focused on the role of the nursing profession in this collaborative process between patient and multidisciplinary rehabilitation team. The question we aimed to answer was:

How can nurses contribute to goal setting and achieving activities in geriatric rehabilitation, and what does this reveal about their professional role within this context?

Our first study (Chapter 2) was a narrative literature review with the aim of analysing goal setting and achievement from the perspective of the patient, with the specific aim of examining nursing roles in the process. Knowledge about this aspect of nursing care could strengthen the role of the nursing profession in geriatric rehabilitation and thus improve the goal-setting process for patients. Both the literature about patients' needs regarding goal setting and the nursing role make it clear that the way nurses work in rehabilitation can gain in clarity. We found that patients need to be prepared to collaborate in goal setting and to receive an explanation of their part in that process. The multiplicity of disciplines may cloud patients' understanding of the process. The nurse's planning of the rehabilitation process should be aimed at resolving this issue. Goals need to be meaningful, and patients need support in attaining them. To ascertain whether the nursing profession can meet those needs, we used Kirkevold's functions of stroke nursing as a framework.¹ We found that the interpretive, integrative and consoling functions of Kirkevold's nursing role are suitable to meet these needs. As such, the performance of nurses might be a key factor for successful rehabilitation. However, according to de Vos et al.,² nurses experience a lack of confidence in performing their tasks in the multidisciplinary team. Cameron et al.³ indicate that there is a need for interventions for the setting and achieving of goals if nurses are to play a role in this area. Interventions that are closely linked to the nursing profession and to

the multidisciplinary nature of geriatric rehabilitation will strengthen the interpretive and integrative side of its work. As a result, this will help older patients to play a more active role in their rehabilitation process that is as much as possible tailored to their personal lives and needs.⁴⁻⁶

Therefore the aim of our second literature review (Chapter 3) was to explore working interventions on setting goals and working with goals designed for nurses in geriatric rehabilitation, and to describe their distinctive features. We found 13 articles describing 11 interventions. The interventions appeal to four aspects of the nursing profession: assessing self-care skills incorporating patients' preferences; setting goals with patients, taking into account personal needs and what is medically advisable; linking the needs of the patient with multidisciplinary professional treatment and vice versa; and thus playing an intermediate role and supporting goal achievement. The interventions show that in goal-centred care, the nurse might play an important unifying role between the patient and the multidisciplinary team. With the support of nurses, the patient may become more aware of the rehabilitation process, and transfer of ownership of treatment goals from the multidisciplinary team to the patient might be achieved. Not many interventions were found that are aimed at supporting the nursing role. This may indicate a blind spot in the rehabilitation community to the value of its contribution. Additionally, involving family members was not addressed in the interventions in a way that does justice to their important role.

Of the 11 interventions, six provide a sufficiently clear description of the nursing role in an inpatient rehabilitation setting. These six interventions can be categorised into three types. The first type of intervention focuses on goal setting with the patient in the admission phase, with the aid of a scale that measures the degree of independence in certain functions (Lorensen's Self-Care Capability Scale⁷ and the Collaborative Functional Goal Setting⁸). The second type of intervention focuses on increasing patient participation to personalise the rehabilitation trajectory, using the Motivational Interviewing Intervention⁹ or the Increased Participation Intervention.^{10,11} The third type of intervention is meant to provide support for patients as they work on short-term goals using an exercise book or goals written on a whiteboard (map with prescribed exercises¹² based on the Dutch Stroke Guidelines¹³ or the Collaborative Patient Goal-Setting Initiative¹⁴).

With the aim of further exploring and clarifying the extent to which these six interventions align with the professional view of nursing staff in geriatric rehabilitation in the Netherlands, we designed a focus group study (Chapter 4). With 23 geriatric rehabilitation nurses, we reflected on the role they could play in the multidisciplinary team in relation to patients' setting and achieving of goals. In the focus group interviews, the six interventions, as well as their underlying vision and elaboration in activities, were used as a means for this reflection. We found that members of

nursing staff in geriatric rehabilitation see themselves as playing a coordinating role in the multidisciplinary team, supporting the patient in goal work. Cooperating with family members was seen by the participants as an important task of nursing staff. Interventions aimed at advancing patient participation and providing support for short-term goals reinforce this role. Additionally, the nurses stated that working on short-term goals is of great value to patients. Setting goals in the admission phase is primarily the task of the multidisciplinary team rather than the nursing staff.

Parallel to the two literature reviews and the focus group study, we performed participatory action research (PAR) on a geriatric rehabilitation ward, described in Chapter 5. The nursing team explored different working methods concerning goal setting and achievement, with the aim of refining their patient-centred care. In the first PAR cycle, the team tried out preparing the multidisciplinary team meeting with the patients. Even though it became clear that these conversations did not obviously contribute to enhanced patient involvement, the nurses wanted to proceed with this way of working. They emphasised the importance of talking with the patient about steps to be taken towards discharge. Clarity about responsibilities in the multidisciplinary team was a prerequisite for nurses to take on this role adequately. The talks also proved to be beneficial for the nurses' intermediate role between the patient and the multidisciplinary team. In the second PAR cycle, it became clear that working with goals on a whiteboard in the patient's room had a positive effect on patient involvement in the rehabilitation process. An additional benefit was that nurses gained knowledge about a wider range of professional rehabilitation domains as a result.

The involvement of nurses in research and quality improvement as practised by us through PAR, is desirable as nurses are often aware of weaknesses in care or organisational processes. In PAR, practitioners are encouraged to identify problems they encounter and, together with the researcher, develop strategies to solve these problems.¹⁵⁻¹⁷

To evaluate the process of involving nurses in PAR, as well as learn what hampers and facilitates collaboration between the nursing team and the researcher and facilitator, we deductively analysed the data collected during the 2.5-year PAR process with the nursing team (15–18 participants). Seven quality criteria (collaboration, prudent handling of assumptions, accountability, participation, reflection, knowledge sources, and transparency) served as a framework for this analysis.¹⁸ Chapter 6 describes the results. The study uncovered that providing the time and setting for reflection and collective learning enabled the nursing team to be actively involved in PAR: it helped them diagnose their current practice, plan ahead, and critically experiment with actions. Additionally, a positive learning climate was a prerequisite for this process. The setting was a learning and innovation network in which reflection and collective learning were core processes, using complementary knowledge sources (theoretical

models, knowledge based on practical experiences, and results of empirical research collected during the PAR). This led the nursing team to draw honest conclusions about their nursing practice and self-selected solutions.

However, there was a weak link between the PAR and the organisation's overall quality policy, which might influence the sustainability of the changes in the nurses' professional practice. PAR supported by a shared governance structure might well solve these issues. Firstly, a structure that covers and connects all layers of the organisation and formally arranges participation, democratic decision-making and accountability establishes a substantive and natural link between management's goals and what happens on the wards. Secondly, it guarantees nurses' involvement and engagement at all stages of PAR. Specifically in the light of the new Dutch legislation¹⁹ that gives nurses a say in their organisation's care policies, we recommend PAR as a method to shape shared governance and allow nurses to take on the role they deserve in improving their practice.

2 | REFLECTION ON THE FINDINGS

Having summarised the five separate studies, we must reflect on their collective contribution to the knowledge about the nursing role in geriatric rehabilitation when it comes to goal setting and achieving.

2.1 | GERIATRIC REHABILITATION: A CONFUSING SETTING FOR PATIENTS

Goal setting has proved to be a process driven by professionals aimed at preparing patients for discharge. This process is often unclear and lacks relevance for patients: goals formulated by professionals may hold little meaning from the patient's perspective, and both the setting, resembling a hospital in which just shortly before they were being cared for, and the involvement of multiple disciplines may confuse patients. Given their cognitive frailty and the post-acute situation in which they find themselves, they might ask themselves: Where am I? Who are all these people? To whom can I address which question? What is expected of me? That is if these questions come to them at all, because the big question on their mind is probably: Will I ever get better and get home again?

2.2 | THE NURSE'S INTERMEDIATE ROLE: GOAL TALK AND GOAL WORK

The literature review (Chapter 2), the scoping review of nursing interventions (Chapter 3) and the focus group study (Chapter 4) together provide a clear picture of the way in which the nursing profession can meet patients' needs. By acting as an intermediary between the multidisciplinary team and the patient, the nurse helps to clarify the situation for the patient and communicate the ward's possibilities regarding the prospect of returning home. The nurse explains how the newly learned techniques relate to activities important to the patient, thereby underlining the personal value of exercising. Meaningful exercises will have motivational power; thus patients'

engagement in their rehabilitation process will be promoted. In practice, this means that a constant dialogue with the patient about goals should determine their daily work. We refer to this as ‘goal talk’. Supporting patients practically and emotionally to work on goals, we refer to as ‘support in goal work’. Intermediation implies a two-way process. Through this constant dialogue and support in working on goals, the nurse is in the best possible position to be the patient’s advocate and inform allied health colleagues about the patient’s progress and concerns, which ideally will lead to a more personalised approach by the whole rehabilitation team. To be able to perform this role, the nurse needs to oversee the entire rehabilitation process, stay ahead, and coordinate and plan efforts of involved healthcare professionals. Loft et al.²⁰ characterise this as a key aspect of the nurse’s role.

2.3 | FURTHER EXPLORING ‘GOAL TALK’ AND ‘SUPPORT IN GOAL WORK’

In the PAR, we focused primarily on the nurse–patient relationship, further exploring ‘goal talk’ and ‘support in goal work’. On a geriatric rehabilitation ward, we tried out two goal setting interventions to enhance patient engagement. Firstly, the nursing team prepared the multidisciplinary team meeting (MTM) with the patient. This ‘goal talk’ conversation was meant to evaluate progress on rehabilitation goals. We expected that this would help the patient make sense of their situation and thus enhance patient participation. This proved not to be the case, although it was appreciated by patients as a form of attention: it boosted their trust in the team of clinicians to know that they were concerned with their progress. Working with tangible whiteboard goals, a specific form of ‘support in goal work’, made a positive contribution to the engagement of the patients involved (n=9). It also made clear that enhancing patients’ involvement in their rehabilitation process with these goals requires a highly individual approach and varies according to each person’s health, worries, context, values, and character or characteristics. The collaboration of patient and professional in order to come up with goals on the whiteboard can be seen as a genuine example of shared decision-making. The rehabilitation professional comes up with ideas for goals, clarifying the process and what has to be done to reach certain more long-term goals. The patient, who now understands the need to exercise, adjusts the whiteboard goals to their values, character and concerns, etc. As a result, the professional understands which specific goals this patient needs.

2.4 | CONCERNS INSTEAD OF GOALS

I would like to reflect on the role of the professional in this process of shared decision-making, referring to two studies. Firstly, Cai et al.²¹ studied goal setting practice within a patient-centred subacute care model. Their study involved asking and documenting patients’ primary concerns, not just their goals. Patients’ goal statements are usually indicative of their ultimate goals, while patients’ concerns mainly serve as short-term goals. The authors found that patients’ goals are relatively consistent over time, while concerns are more dynamic and subject to change.

These concerns need to be understood by the professional to facilitate effective care planning. Cai et al.'s study²¹ shows that airing concerns helps professionals understand what patients need. Both Cai et al.'s study and our study indicate that to enhance patient engagement in goal achievement, professional engagement with concerns is strongly recommended.

2.5 | GOAL TALK IN FOLLOW-UP PHASE NEEDS ATTENTION

The systematic review of Kang et al.²² indicates that professionals might not invest enough time in this particular aspect of the goal setting and achieving process. The authors examined what components are used in current person-centred goal setting interventions for adults with health conditions in rehabilitation. Following Lenzen et al.²³ they distinguish five phases in goal setting interventions: preparation, formulation of goals, formulation of an action plan, coping planning, and a follow-up phase. The follow-up phase, in which goal progress is monitored with the patient, is missing in 41 percent of interventions. As a result, goals might become less appropriate; exercise behaviour may also decline, because progress towards targets and the concerns that impede that progress are not discussed. Turner-Stokes et al.^{24(p210)} provide a suitable description of this: ideally, goal planning should form part of an educational process in which patients and their families are engaged not only in setting goals for rehabilitation, but in taking responsibility for monitoring, achieving and re-setting those goals along the journey of their recovery.

2.6 | ADVOCATE ROLE VERSUS PATIENT AUTONOMY

As previously stated, our main focus in the PAR was the nurse–patient relationship; however, we inevitably learned lessons about nurses' intermediate role in relation to the multidisciplinary team. Working with short-term goals with patients showed that nurses gained knowledge on a broader span of rehabilitation expertise, a prerequisite for fulfilling the intermediate role. Additionally preparing the MTM provided nurses with valuable insights into a patient's progress. The preparation enabled nurses to gain a deeper understanding of patients' aspirations and challenges, a prerequisite for playing the advocate role and leading to more patient-centred care. In this day and age when patients' self-direction and autonomy are sought and encouraged, pleading for the nurse to play an advocate role might seem paternalistic. However, our focus group study (see Chapter 4) demonstrated that nurses are adept at the nuanced process of assessing the degree of control a patient is capable of taking in the goal setting process, attuning to that level of control in their advocate role and creating conditions that enable patients to exercise as much control as possible. Involving relatives is part of this, so they can exercise control together. Family can reinforce the patient's sense of agency, facilitate communication, and provide essential support in aligning rehabilitation goals with the patient's preferences and capabilities. Last but not least, they can assist the patient in working towards these goals, thus facilitating the transfer home and reducing carer strain.²⁵

2.7 | THE INTERMEDIATE ROLE: INTERPROFESSIONAL TEAMWORK CHALLENGES

Several challenges that restrain nurses from fully embracing their intermediate role were identified through the research process, the main two being suboptimal interprofessional teamwork (or silo practice) and lack of continuity. Our first study showed that patients do not realise that rehabilitation is a 24/7 process. As mentioned above, the involvement of multiple disciplines, while beneficial for geriatric rehabilitation, may confuse older patients. In this light, the focus group study (Chapter 4) revealed a major limiting factor for nurses to take on this intermediate role. The participants shared that nursing issues are not yet recognised as an integral part of rehabilitation practice. Typical nursing issues (like wound care and independent handling of medication) are lacking in the admission phase. As the current patient population gets older and can be characterised as more complex and dependent,²⁶ nursing issues require increased attention and nurses need to provide more clinical care (e.g. wound care, nutrition and hydration support, monitoring vital signs, preventing complications such as delirium and pressure sores, managing pain) in addition to rehabilitation care. As long as this type of care is not acknowledged as an essential part of geriatric rehabilitation, nurses will mainly stick to clinical care, assuming that this is their specific responsibility on a geriatric rehabilitation ward. This might prevent them from taking on the rehabilitation role and supporting the patient in achieving goals. In the focus group study, the nurses, reflecting on their task of supporting patients in working on daily goals formulated by other allied health professionals, also showed silo thinking between care and rehabilitation. Some participants were hesitant to incorporate this in their work (*Why me? It feels like they are shifting tasks onto me*). The PAR also revealed consequences of silo thinking. Nurses experienced apprehensiveness in fully embracing their connecting role. Not trusting their assessment of patients' situation, they hesitated to put a patient on the multidisciplinary consultation agenda or to add or remove goals from the patient's plan. The nurses had to be convinced that their attention was expected not only on the nursing goals focused on activities of daily living but also, importantly, on the goals formulated by the physiotherapist. While collaborative team work is crucial for achieving quality rehabilitation outcomes,^{27,28} it cannot be assumed that health professionals have a clear understanding of each other's roles and competencies or are adequately prepared to function effectively within a multiprofessional care team.^{28,29} This could be especially the case for Dutch nurses working in geriatric rehabilitation because they were originally educated to provide comfort to older people in the last phase of their lives.

2.8 | THE INTERMEDIATE ROLE: LACK OF CONTINUITY

A second important barrier for the nursing profession to fully take on the intermediate role is the lack of continuity through shift work and of consistent patient assignment to nursing team members. This way of organising care, known as primary nursing, is a model of care delivery that is said to support patient involvement, as a primary nurse is responsible for coordinating all aspects of care.³⁰ Without patient assignment,

building a relationship with the patient is hindered, making it harder to understand their preferences, concerns, goals and progress, which is key to guiding their recovery effectively. Additionally, Ehrlich et al.²⁸ state that in inpatient rehabilitation care settings, nurses have limited access to formal opportunities for collaboration with other disciplines, like team meetings, as their priority is to remain present with the patients on the ward to provide care. This also affects continuity of care. While medical staff and allied health professionals have relatively stable schedules, nurses work rotating shifts with constantly changing work patterns.^{6,20,28} During MTMs, a single nurse often represents the nursing perspective for all patients, which may impact the accuracy of the information shared.^{28,31}

2.9 | REFLECTIONS ON INVOLVING NURSES IN THIS RESEARCH

Our focus group study and the PAR highlighted the valuable insights and practical experience nurses bring to envisioning a better working environment. Our PAR also showed that doing research in this way, in the setting of a learning and innovation network with nurses, led to relevant improvements in terms of practice and fun and fulfilment. However, we experienced that PAR requires substantial time and effort from both researchers and participants, which can be challenging to achieve within normal working hours. Also, changes in practice require long-term evaluation, but PAR studies often focus on shorter timeframes, making it difficult to determine the sustainability of improvements.

3 | IMPLICATIONS FOR EDUCATION

As stated before, the nursing profession needs to be more aware of the central role that nurses can play in intermediating between the patient and the multidisciplinary team. Both the scoping review (Chapter 3) and our focus group study (Chapter 4) showed that nurses working in geriatric rehabilitation require additional training to incorporate rehabilitation practices into their daily routine through, among others, working systematically with patients' goals. Targeted behaviours of rehabilitation training should be: talking with and involving patients systematically in the goals, every day and on every shift; making sure always to know the patient's goals—long term and short term—before starting the care session; and using appropriate language to explain the rehabilitation process to patients' relatives.³² Both the focus group study (Chapter 4) and the PAR (Chapter 5) highlighted the importance of training in motivational interviewing as essential for enabling nursing staff to shift from a traditional caregiving role to one focused on coaching patients towards achieving their personal goals. Furthermore, both studies showed that educational programmes for nursing staff need to include training on the intentional use of structured care plans, documenting process and progress. Developing this skill is essential to enable nurses to actively support patients' participation in rehabilitation and to confidently assume a coordinating role in the care process. Several authors emphasise the need for specialised education.^{33,34}

Gutenbrunner et al.^{33(p2)} state: ‘Education of nurses has to include an in-depth understanding of the role of rehabilitation in improving functioning as well as nursing interventions leading to this goal’. Ideally, training should go hand in hand with certain practice implications, which I will describe in the next section.

4 | PRACTICE IMPLICATIONS

Our study showed that the current lack of an interprofessional approach and continuity does not support the nursing contribution to a patient-centred rehabilitation process; nor does it support the connecting role of the nurse between the patient and the multidisciplinary team. This leads to implications for the content and structure of information exchange about patients’ progress.

4.1 | INCORPORATING NURSING INTO INTERPROFESSIONAL ADMISSIONS

To start with, specific nursing focus points should be incorporated into the admission process. Older patients entering geriatric rehabilitation often have specific care needs that need to be answered before they can start their rehabilitation trajectory. If, in the admission phase and in the system that sums up the goals, we focus mainly on functional goals, rehabilitation will remain the preserve of other disciplines in the eyes of the nursing profession.

4.2 | ENABLING ‘GOAL TALK’ IN WORK PRACTICES

Secondly, working procedures and materials should facilitate the joint ‘goal talk’ process between patients, family and nurses, and increase the clarity of the rehabilitation process and its possibilities for patients. Preparing the MTM with the patient is an obvious way to substantiate this. Furthermore, Doornebosch et al.³⁵ demonstrated in their observational study on interprofessional collaboration during MTMs in geriatric rehabilitation that when patients are represented by a team member who has collected information from them prior to the MTM, it enhances the identification of well-defined, person-centred goals that the team should work on interprofessionally. But work procedures should allow for more ‘goal talk’ possibilities anyway, not merely as preparation for the MTM. In our PAR, working with whiteboards showed how this specific form of ‘goal talk’ supported the patient to work actively on goals and how it strengthened the intermediate role of the nurse.

4.3 | SHARED GOALS AND CONTINUITY

Thirdly, continuity of care is important in building a relationship of trust within which patients are invited to share their personal preferences. Patient allocation will enhance informal ‘goal talk’ and thus foster patient-centred care. For nurses to perform these ‘goal talks’, working on shared patient-centred goals in the multidisciplinary team is a prerequisite. The use of overarching patient-centred goals unites team members around a shared purpose, where they would otherwise be pursuing separate discipline

specific practices.⁶ It allows the nurse to do ‘goal talk’ on these patient-centred goals and inform relevant members of the multidisciplinary team about progress. Working in this way allows for a unified and therefore clearer approach towards patients. Based on our studies, we argue that to ensure that the patient experiences more unity in the approach, the nurse needs to adopt this intermediate role between the disciplines and the patient.

4.4 | INCLUDING NURSES IN FORMAL TEAM MEETINGS

A fourth recommendation is that, as an aspect of continuity, nurses should be facilitated to attend the MTM and represent the patient to whom they are allocated. Also, nursing issues should be addressed there as well as rehabilitation issues. Ehrlich et al.²⁸ found that including nurses in formal team meetings will lead to improved informal collaboration. Recent research on multidisciplinary team healthcare professionals’ perceptions of optimal rehabilitation states that a positive team culture is mainly the result of good communication, achieved through MTMs, bedside whiteboards, staff note systems, and clinical governance meetings, which help align the attitudes, values and care approach of healthcare professionals.³⁶

4.5 | CLEAR VISION OF NURSING ROLE

Like Guerra et al.³⁶ I consider facilitating all the above mentioned structural elements a task that lies heavily on senior management. Ruijters³⁷ states that for organisations, working with professionals has certain implications—for example, expectations have to be articulated. Geriatric rehabilitation managers need to have a clear vision of what geriatric rehabilitation encompasses, what role the nursing team should play, and support multidisciplinary teams to organise the work accordingly. Clear working procedures and role definitions are needed, as well as interventions that support these procedures and roles. This will help nurses overcome apprehensiveness about their role and help them to see themselves as an equal partner of the multidisciplinary team. Working procedures legitimise certain activities, make these activities less person dependent and foster responsibility. According to Ruijters^{37(p47)}: ‘Since a strong professional identity underpins consistency in behaviour, others will also recognise you as such, expect things from you and ask questions in the one area where you have answers to offer’.

4.6 | GIVING NURSES A VOICE WILL LEAD TO SUSTAINABLE CHANGES

Making managers responsible for organisational structures that facilitate the nurse in playing the connecting role between patient and multidisciplinary team does not diminish the contributions of nurses (and other healthcare professionals) in shaping the ideal structure. On the contrary, both our focus group study and the PAR underscored the valuable contributions nurses make in shaping a better work environment. Conducting research with nurses within a learning and innovation network not only led to meaningful and lasting improvements in practice, but also

brought energy and enjoyment to those involved. These are compelling reasons to embed this approach into everyday healthcare and nursing practice—especially in light of new Dutch legislation¹⁹ that formally recognises nurses’ influence on care policy. PAR supported by a shared governance structure might well solve the issue of sustainability and might provide a structure for permanent learning and innovation. To begin with, an organisational structure that encompasses professionals and managers and formally integrates participation, democratic decision-making and accountability creates a meaningful and natural connection between management’s goals and the activities and quality issues in the wards. Secondly, these organisational structures should ensure nurses’ involvement and engagement throughout all stages of PAR. Strengthening the connection between management and staff also fosters mutual understanding, promoting a more sustainable relationship between research and practice.³⁸ According to Dedding et al.,³⁹ achieving this relationship requires policymakers and researchers to adopt more creative and inclusive approaches, like engaging in co-creation processes, involving frontline professionals and patients in decision-making, and designing research agendas that reflect real-world practice needs. Otherwise the dialogue between nurses and management risks being limited to traditional board governance with some staff input.⁴⁰ I dare to claim that this will not lead to sustainable changes.

5 | FUTURE RESEARCH

Building upon the findings of this thesis, I recommend further research on three topics.

5.1 | REFINING THE MTM PREPARATION: HELPING PATIENTS TO PREPARE

Firstly, research is recommended to explore how patients can be optimally involved in the preparation of MTMs in a geriatric rehabilitation setting. To this end, a PAR approach is proposed, involving patients, family, nurses, and other members of the multidisciplinary team on a geriatric rehabilitation ward. This recommendation is informed by the focus group study conducted as part of this thesis. During one of the sessions, a nurse described a newly initiated practice in which patients are invited to complete a questionnaire prior to the MTM to help them prepare and reflect on what they would like to contribute. Although a PAR study has already been conducted as part of this thesis, focused on engaging patients in their rehabilitation process, further work is needed to refine the procedures used. The specific step of asking patients to reflect on their process prior to the talk with the nurse was missing in the seven-step plan tried out in our PAR and might be an important addition. A future study could explore, in a collaborative and iterative manner, how tools or practices such as the questionnaire mentioned can be aligned to patients’ needs concerning involvement, how family can get a share in the whole process, and how these tools and practices can be effectively implemented.

5.2 | IMPROVING COMMUNICATION IN MTM PREPARATION

In our PAR (Chapter 5), we found that the patients were not fully aware of the main purpose of the interviews to prepare the MTM. The nurses attributed this to patients' unfamiliarity with such an active role; also, they experienced that in the nurse–patient dynamic, the patients seemed more inclined to help the nurse gather information than to articulate their own worries.

In their study about shared decision-making, Lenzen et al.⁴¹ confirmed that it can be difficult for nurses to develop a collaborative partnership with the patient because they feel responsible for the patient's situation. Their study also revealed the influence of contextual factors, such as being driven by external (financial) targets. To understand the process of how patients and nurses negotiate roles and interpret the purpose of the interview, I suggest performing a qualitative study. In-depth interviews with patients after the MTM preparation will serve to explore how they felt in the interaction and what they felt comfortable sharing. Listening to taped interviews and reflecting with nurses on specific interactional moments might uncover how nurses' interactional cues shape power dynamics and if they feel there is room to change this or that they are restricted by organisational targets. Results can be used to create materials for nursing education in communication but also uncover conflicting ambitions within geriatric rehabilitation care.

5.3 | PAR ABOUT THE NURSE–MULTIDISCIPLINARY TEAM RELATIONSHIP

A third recommendation for further research concerns the role of the other members of the multidisciplinary team towards nurses. Nurses can hold a pivotal intermediate position in the rehabilitation team. Positioned close to the day-to-day experiences of patients, they are uniquely situated to support patients in articulating their goals, concerns and questions. At the same time, they act as mediators between patients and the wider team of professionals, translating clinical perspectives into accessible language, advocating for patients' preferences, and supporting the team in making shared decisions. Of this dual positioning, we have mainly focused on the nurse–patient relationship. Lessons about the nurse–multidisciplinary team relationship emerged and these need to be explored more extensively. For this subject, I also recommend performing PAR. Starting from the premise that the nurse fulfils this intermediate role, nursing team members and allied health professionals can explore their relationship, discuss the responsibilities and expectations of the wider team and, for example, experiment with a stronger role in the MTM. By doing so, the study could provide concrete strategies to improve team communication, strengthen the collaborative planning of rehabilitation care, and ultimately enhance patient participation.

6 | METHODOLOGICAL CONSIDERATIONS

I would like to conclude this chapter with a look at a limitation and a strength of the research described in this thesis.

6.1 | DEALING WITH BIAS

An issue of concern during the whole research process was how to be a PAR researcher and an opinionated nursing leader at the same time. As a former nurse, my professional background and experiences inevitably shaped my perspective on the role of nurses in multidisciplinary teams and their involvement in goal setting activities. This positionality brings both strengths and potential biases to the study. My experience as a nurse may have influenced my interpretation of findings; I may have unconsciously emphasised data, framed questions or interacted with participants in a way that aligns with my belief that nurses should take on a more central role. Interacting with the participants, I can confidently say that I was responding from my belief that nurses should play a more central role: during the PAR it genuinely pleased me to hear nurses share their positive experiences of preparing the MTMs. To address these biases, and enhance credibility and dependability, I reflected both with my supervisors from diverse backgrounds and with my PAR workgroup members on how my background influenced the study design, data interpretation and conclusions. Through the combination of a narrative review, scoping review, focus groups and PAR, we also sought to promote credibility by incorporating multiple perspectives and thus reducing the risk of a one-sided interpretation.

6.2 | THE COMBINATION OF FOUR RESEARCH APPROACHES

I would like to conclude this general discussion with a strength of this thesis—the combination of four research approaches: a narrative review, a scoping review, a focus group study, and PAR. Each method contributed to an overall understanding of the nursing role in geriatric rehabilitation, specifically in relation to goal setting and achieving activities. The narrative review synthesised existing literature on patients' needs regarding goal setting in geriatric rehabilitation, providing an understanding of their perspectives and expectations. The scoping review systematically mapped nursing interventions related to goal setting, identifying core elements of existing practices and the impact of the interventions. Together, the narrative and the scoping review enhance the credibility of the research by establishing a theoretical basis for understanding the topic, ensuring that subsequent empirical studies concerning nursing interventions are grounded in the latest research findings.

It has been important to me to present the accumulated knowledge gathered through the reviews to geriatric rehabilitation nurses in practice. My research was meant to be with and for nurses, not merely about them. A focus group study was performed to reflect on this knowledge with them and connect theory and practice. This study explores their perspectives, experiences and perceived roles in goal setting, offering real-world insights into practical challenges and opportunities. The PAR goes a step beyond exploration by actively engaging a nursing team in improving their goal setting practice. This approach ensures that the research is not only descriptive but also transformative, leading to improvements in care delivery. The participatory nature

promotes ownership and sustainability of changes, as nurses themselves drive practice improvements. By providing thick descriptions and direct quotations, we have striven to make this research as transferable as possible. With Green and Thorogood,^{42(p309)} we note that ‘the key elements that are generalisable from qualitative research may not be the narrow findings but the concepts, that is the way of thinking about or making sense of the world’. Hereby we hope to inspire others involved in geriatric rehabilitation to reflect on and change their practices. This multi-method approach bridges the gap between research and practice, identifying challenges as well as testing solutions, thus making it a robust approach for improving nursing practices in geriatric rehabilitation. Let’s make this common practice in healthcare.

7 | CONCLUSION

Staff shortages in care for older adults are expected to worsen in the coming years.⁴³ To prevent outflow from the profession, job satisfaction deserves more attention. Job satisfaction is related to nurses being able to exercise autonomy over their own practice.⁴⁴⁻⁴⁶ Nurses in general, but also specialised nurses like geriatric rehabilitation nurses, need a shared understanding of their role and function to be able to exercise autonomy. This thesis has made clear that nurses in geriatric rehabilitation have the potential to play a pivotal intermediate role between patients and the multidisciplinary team. Goal talk and support in goal work will clarify the rehabilitation process for patients. This might enhance relevance and meaning for their daily lives and result in greater motivation and participation. Supported by education, by interventions and by managers with a clear vision of the value of nursing within interdisciplinary care, this role can be further developed and embedded in daily practice, contributing not only to better patient outcomes, but also to greater professional fulfilment and retention among nurses.

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**SUMMARY
PUBLIEKSSAMENVATTING
DANKWOORD
PHD PORTFOLIO
ABOUT THE AUTHOR**

SUMMARY

Older people who have experienced a major health event can rehabilitate in a geriatric rehabilitation setting before they return home. Joint goal setting between the patient and healthcare professionals is a method used to help patients work purposefully towards discharge. By aligning professional expertise with the goals, life aspirations and capacity of the person needing rehabilitation, patients' engagement in their rehabilitation process can be promoted. This thesis focused on the role of the nursing profession in this collaborative process between patient and multidisciplinary rehabilitation team. The question we aimed to answer was:

How can nurses contribute to goal setting and achieving activities in geriatric rehabilitation, and what does this reveal about their professional role within this context?

The narrative review (**chapter 2**) analyzed goal setting in geriatric rehabilitation from the patient's perspective. Patients need clarity and support to engage in meaningful goals. Using Kirkevold's framework, the study found that nurses can meet these needs, though tailored interventions remain necessary if nurses are to play this role.

The second literature review (**chapter 3**) explored 11 nursing interventions in geriatric rehabilitation focused on goal setting. Findings highlight nurses' potential as intermediaries linking patients and multidisciplinary teams. Family involvement remains insufficiently addressed in the interventions.

Six of eleven interventions clearly define nursing roles in inpatient geriatric rehabilitation, grouped into goal setting at admission, enhancing patient participation through regular talks about progression, and supporting working on short-term goals. A focus group study with 23 nurses (**chapter 4**) confirmed their coordinating role in goal work, valuing family cooperation and emphasizing the impact of working with short-term goals.

In a participatory action research study, nurses on a geriatric rehabilitation ward tested new goal-setting methods (**chapter 5**). The nursing team trialed preparing multidisciplinary meetings with patients. Though these talks didn't clearly boost patient involvement, nurses valued discussing discharge steps and saw benefits to their intermediary role. In a second cycle, using whiteboards in patient rooms positively impacted engagement and expanded nurses' understanding of broader rehabilitation domains, reinforcing their role within the multidisciplinary team and improving overall coordination.

Involving nurses in research through Participatory Action Research (PAR) is valuable, as they often identify care and organisational issues. Our evaluation of the 2.5-year PAR

study with 15–18 nurses (**chapter 6**) showed that structural reflection and a supportive learning climate enabled active participation, self-assessment, and practical improvements. Using seven quality criteria, the study found that combining theoretical, experiential, and empirical knowledge fostered honest evaluation and solution-building. However, a weak connection with broader organisational policy on quality threatened sustainability. Embedding PAR within a shared governance framework could bridge this gap, aligning ward-level actions with strategic goals and enhancing nurses' influence under new Dutch legislation supporting professional autonomy.

The general discussion (**chapter 7**) reflects on the results and describes recommendations for education, practice and future research. The findings of this thesis highlight the vital role nurses play in geriatric rehabilitation, particularly in supporting patients with goal setting and achievement. It became clear that goal setting is often led by professionals with little relevance to patients' personal perspectives, especially in a confusing clinical environment. Nurses are uniquely positioned to act as intermediaries—translating medical goals into meaningful personal objectives for patients and guiding them through the rehabilitation process through “goal talk” and “goal work.”

Key barriers to nurses fully adopting their intermediate role include siloed interprofessional teamwork, lack of continuity due to shift-based work, and the dual nature of nursing in rehabilitation: working clinical as well as rehabilitative. Nurses in the study expressed hesitation in taking responsibility for broader rehabilitation goals. Educational and practice implications include enhancing nurse training in communication, motivational interviewing, and structured care planning. Systemic changes are also necessary, including better continuity through patient allocation, improved interdisciplinary collaboration, and stronger organisational support. Overall, empowering nurses as central actors in patient-centred rehabilitation can lead to improved care quality and patient engagement. Future research should focus on three areas: (1) refining MTM preparation by involving patients and families more effectively using tools like questionnaires; (2) improving nurses' communication skills and understanding patient–nurse dynamics through ethnographic studies; and (3) exploring the nurse–multidisciplinary team relationship via PAR to strengthen collaboration and enhance patient participation in geriatric rehabilitation.

Chapter 7 concludes by acknowledging both a key methodological limitation and a strength. The author's dual role as PAR researcher and experienced nurse introduced potential bias, influencing data interpretation and interactions. To address this, reflexive discussions with supervisors and PAR members were used to enhance credibility. A core strength lies in the multi-method approach—narrative review, scoping review, focus groups, and PAR—which provided theoretical grounding, practical insight, and active engagement with nurses. This combination ensured the research was both

evidence-based and transformative, promoting sustainable improvements in practice. The study aims to inspire reflective change in geriatric rehabilitation nursing through collaborative, practice-driven research.

Amid growing staff shortages, enhancing job satisfaction is crucial to retain nurses. Autonomy and a clear professional identity are key. Geriatric rehabilitation nurses can play a vital intermediary role by supporting patients in goal setting, making care more meaningful. With proper support, this enhances both patient outcomes and nurses' professional fulfilment.

PUBLIEKSSAMENVATTING

INLEIDING

Ouderen die na een ziekenhuisopname niet sterk genoeg zijn om weer zelfstandig thuis te wonen, kunnen revalideren op een geriatrische revalidatie afdeling. Op zo'n afdeling werken allerlei professionals die deze ouderen ondersteunen in het toewerken naar ontslag: artsen, fysiotherapeuten, ergotherapeuten, diëtisten, logopedisten, psychologen en verpleegkundigen en verzorgenden¹. Met de oudere en eventueel met diens naasten wordt een plan opgesteld met doelen die bereikt moeten worden om weer naar huis te kunnen. Dit plan geeft ouderen houvast in hun proces én helpt al die betrokken disciplines om het overzicht te houden op de voortgang van de cliënt. In de praktijk heeft het werken met doelen nog geen optimale vorm gekregen. De oudere wordt niet altijd adequaat betrokken bij het opstellen van de doelen, daardoor zijn de doelen onvoldoende afgestemd op persoonlijke behoeftes en is de oudere zich dikwijls niet goed bewust van die doelen. Ook worden de doelen tijdens de opnameperiode niet als leidraad gebruikt in de voortgangsgesprekken met de oudere, zoals eigenlijk wel de bedoeling is.

WELKE ROL KUNNEN VERPLEEGKUNDIGEN EN VERZORGENDEN SPELEN?

Dit proefschrift gaat over de rol die verpleegkundigen en verzorgenden kunnen spelen in het revalidatieproces met als focus het werken met doelen, samen met de cliënt. De onderzoeksvraag luidde:

Hoe kunnen verpleegkundigen en verzorgenden in de geriatrische revalidatie werken met revalidatiedoelen en wat zegt dit over hun professionele rol binnen deze context?

Om deze vraag te beantwoorden, zijn de volgende onderzoeken uitgevoerd:

1. Een literatuurstudie: *welke behoeftes hebben ouderen als het gaat om het werken met doelen in de revalidatie en sluit dat wat de verpleegkundige te bieden heeft daarop aan?*
2. Een literatuurstudie: *welke verpleegkundige methodieken zijn er als het gaat om het ondersteunen van cliënten in het werken met doelen in de geriatrische revalidatie?*
3. Een focusgroepestudie waarin we een deel van de gevonden methodieken hebben voorgelegd aan verpleegkundige en verzorgende experts in de geriatrische revalidatie. Met hen bestudeerden we de activiteiten die in deze methodieken worden beschreven, met als doel het verder verhelderen van de rol van de verpleegkundige en verzorgende in de geriatrische revalidatie.
4. Een participatief actieonderzoek met het team van verpleegkundigen en verzorgenden op een geriatrische revalidatie-afdeling. In dit onderzoek richtten teamleden zich op de vraag hoe zij als team hun clientgerichte werkwijze konden ontwikkelen met behulp van twee interventies op het vlak van werken met doelen.

5. In een vijfde onderzoek is geëvalueerd of en hoe het is gelukt om de verpleegkundigen en verzorgenden van de geriatrische revalidatie-afdeling en de stagiaires te betrekken bij het participatief actieonderzoek.

WERKEN MET DOELEN: WELKE BEHOEFTES HEBBEN OUDEREN?

Uit de eerste literatuurstudie blijkt dat het voor cliënten niet volledig duidelijk is wat de bedoeling is van een opname op een geriatrische revalidatie afdeling. Hier zijn verschillende redenen voor. De oudere bevindt zich in een kwetsbare positie door de reden voor de ziekenhuisopname (dit kunnen verschillende redenen zijn: een botbreuk door een val, een oncologische behandeling, een hersenbloeding of herseninfarct, verergering van hart- of longklachten, enzovoort). Voorlichting die in het ziekenhuis wordt gegeven over het vervolg van het behandeltraject is vaak niet duidelijk, en ook komt het dikwijls voor dat deze door de oudere niet goed begrepen wordt. Het is voor de oudere, zeker in de eerste periode na opname meestal niet helder wat precies de routines zijn op de geriatrische revalidatie afdeling en hetzelfde geldt voor het werken met doelen dat deel uitmaakt van deze routine. Uit de literatuur kwamen vier aandachtspunten naar voren over de behoeften van ouderen bij het werken met doelen. Allereerst hebben de ouderen behoefte aan uitleg over de setting en ook over de bedoeling van het werken met doelen. Zij vragen zich af waar ze beland zijn. De setting met de vele betrokken disciplines kan verwarring veroorzaken. Ten tweede is het van belang dat de opgestelde doelen voor de oudere ook betekenis hebben. Professioneel jargon zoals bijvoorbeeld ‘functionele afstanden kunnen lopen’ zegt de oudere te weinig. Ten derde moet aan de ouderen worden uitgelegd waarom zij een stem zou moeten hebben in het opstellen van de doelen. Veel ouderen gaan ervan uit dat ‘de dokter/ fysiotherapeut/ zuster dat het beste weet’. De oudere begrijpen niet direct dat het juist belangrijk is om eigen behoeften aan te geven zodat de opgestelde doelen ook goed passen bij hun eigen leven. Ten slotte is het nodig om de oudere hulp te bieden bij het bereiken van het einddoel, door dat doel op te knippen in kleinere stukken. Bij opname zijn ze namelijk niet in staat het gehele revalidatietraject te overzien, waardoor het voor hen onmogelijk kan lijken om een einddoel te halen.

SLUIT DE ROL VAN DE VERPLEEGKUNDIGE AAN OP DIE BEHOEFTES?

Als we kijken naar de rol van de verpleegkundigen en verzorgenden in de geriatrische revalidatie (zoals omschreven door onder andere de Noorse verpleegkundige en onderzoeker Marit Kirkevold²⁾) dan sluit dat goed aan op de genoemde behoeften van ouderen. Kirkevold onderscheidde vier functies in het werk van de revalidatieverpleegkundige. De eerste is de consoliderende functie, die erop gericht is de cliënt in een goede uitgangspositie voor revalidatie te brengen. Hieronder vallen basiszorg voor hygiëne en voeding, evenals preventie en behandeling van problemen zoals decubitus en delier. De tweede functie is die van motiveren en troosten: het bieden van passende emotionele steun, zodat de cliënt het zware werk kan volhouden dat nodig is om doelen te bereiken en terug naar huis te gaan. De derde functie van

revalidatieverpleegkundigen is die van ‘vertaler’: zij leggen uit waar iemand beland is, wat er aan de hand is en hoe het nu verder gaat. Ook helpen zij de ouderen om overzicht te houden door samen met hen vooruit te kijken en te bespreken wat nodig is. Ten slotte is er de vierde, integrerende functie: het zichtbaar maken van de samenhang tussen het persoonlijke leven en de behoeften van de cliënt en de doelen waaraan de professional(s) samen met de cliënt werken in het kader van herstel. Met name de drie laatste functies laten zien dat verpleegkundigen en verzorgenden een belangrijke *verbindende* rol kunnen spelen in de geriatrische revalidatie.

Uit de literatuur blijkt echter ook dat verpleegkundigen en verzorgenden zich niet maximaal vertrouwd voelen met deze verbindende rol. Er is behoefte aan duidelijk omschreven verpleegkundige methodieken die betrekking hebben op het werken met doelen in de multidisciplinaire setting van de geriatrische revalidatie. Door het implementeren van zulke methodieken kunnen verpleegkundigen en verzorgenden zich deze rol meer eigen maken. Als gevolg daarvan zullen cliënten in de geriatrische revalidatie beter begrijpen wat de bedoeling is, zullen doelen adequater aansluiten bij wat voor hen belangrijk is en zullen zij daardoor actiever aan de slag gaan met hun revalidatie.

METHODIEKEN OVER HET WERKEN MET DOELEN

In een tweede literatuurstudie is gezocht naar methodieken die het werken met revalidatiedoelen met cliënten ondersteunen. We vonden elf methodieken waarin de verpleegkundige een rol vervult. De methodieken laten zien dat de rol van verpleegkundigen en verzorgenden er steeds in bestaat om het revalideren op de afdeling te verbinden met het persoonlijke leven van de cliënt. De methodieken laten ook zien dat dit op verschillende manieren kan. In de ene methodiek voert de verpleegkundige regelmatig gesprekken met de oudere over voortgang, in de andere methodiek wordt bijvoorbeeld met een werkboek met oefeningen gewerkt. Er is dus niet één beste manier voor verpleegkundigen en verzorgenden om samen met cliënten doelen op te stellen en hen te ondersteunen in het werken aan doelen. Het is vooral belangrijk dat de verpleegkundigen en verzorgenden zich bewust worden van al deze mogelijkheden, zodat ze die belangrijke verbindende rol tussen de cliënt en het multidisciplinaire team goed kunnen spelen. Wat verder opvalt in de methodieken, is dat familie niet vanzelfsprekend wordt betrokken. Daarnaast verschilt de wijze waarop cliënten betrokken worden bij het opstellen van doelen. In de ene methodiek kiezen de cliënten uit een lijst voorgeschreven doelen, in de andere wordt cliënten gevraagd zelf doelen te benoemen. De literatuurstudie werpt ook enig licht op de vraag wat bijdraagt aan de implementatie van dit soort methodieken, of wat daarin belemmerend werkt. Belemmerend werken: gebrek aan tijd, de visie dat werken met doelen tijdrovend is en ten koste gaat van het oefenen zelf. Daarnaast vormt ook de discontinuïteit van de zorg door het werken in wisselende diensten een belemmering. Bevorderend werkt het als medewerkers worden geschoold in de methodiek(en); als ze ondersteuning

krijgen van bijvoorbeeld een leidinggevende of een opleidingsfunctionaris; en als de verpleegkundigen en verzorgenden vanuit het management worden gefaciliteerd om te werken volgens een bepaalde methodiek.

IN GESPREK MET GR-VERPLEEGKUNDIGEN EN -VERZORGENDEN

In zes van de elf methodieken die we gevonden hebben werd de rol van de verpleegkundige duidelijk beschreven. Over deze zes methodieken zijn we, in focusgroepinterviews, in gesprek gegaan met 23 Nederlandse geriatrie revalidatie verpleegkundigen en verzorgenden. De zes methodieken hebben we met het oog daarop onderverdeeld in drie types: type 1, methodieken waarin tijdens de opnamefase met behulp van een meetinstrument samen met de oudere doelen worden opgesteld; type 2, methodieken waarin de verpleegkundige of verzorgende gedurende het hele revalidatieproces op gezette tijden de voortgang op doelen met de oudere bespreekt, met het oog op een zo persoonlijk mogelijk revalidatietraject en daarmee een gemotiveerde cliënt; en ten slotte type 3, methodieken die de oudere ondersteunen in het werken aan kleinere dagelijkse of wekelijkse oefendoelen. Het doel van deze focusgroepinterviews was niet om de perfecte methodiek te vinden, maar om een scherper beeld te krijgen van de rol van de verpleegkundige en verzorgende in de geriatrie revalidatie. Duidelijk werd dat methodiek type 2 werd gezien als het best passend bij de rol van de geriatrie revalidatie verpleegkundigen en verzorgenden. Tabel 1 geeft een beknopte samenvatting van de gesprekken.

Tabel 1. Beknopte samenvatting focusgroepinterviews.

	Type 1	Type 2	Type 3
Past de methodiek bij de behoefte van de cliënt?	De cliënt moet betrokken worden! Maar de overgang van ziekenhuis naar revalidatie is vaak vermoeiend en door cognitie lukt het ook niet altijd.	De cliënt moet betrokken worden! Dat zouden we nog beter kunnen doen.	Supernuttig, want: - geeft grip op revalidatie, maakt proces behapbaar - motiverend: de revalidant ziet vooruitgang - aanvulling op therapie: revalidant hoeft niet te wachten - geeft informatie aan mantelzorg - zorgt voor eenduidig werken door alle professionals
Past de methodiek bij de rol van de zorg?	Niet heel specifiek voor de zorg, meer iets voor het hele multidisciplinaire team.	Ja! Dit doen we eigenlijk al, alleen nog niet zo structureel op vastgestelde momenten.	Het opstellen van de oefendoelen past meer bij de specifieke discipline. Het motiveren tot oefenen past heel goed bij ons.

In het ideale geval voeren verpleegkundigen en verzorgenden met cliënten constant het gesprek over doelen, hoe daaraan te werken en hoe het daar nu mee gaat. Zij

leggen daarmee steeds het verband tussen wat de verschillende disciplines met de cliënt oefenen en dat wat voor de cliënt belangrijk is in het leven. Zij noemden zichzelf onder andere *helikopter*, *verbinder of coördinator*. Als voorwaarde om die rol tussen de cliënt en de disciplines goed te kunnen spelen, benoemden de verpleegkundigen en verzorgenden in de focusgroepen de interprofessionele manier van werken. Daarmee bedoelden zij dat er één set van doelen is voor de cliënt waaraan alle disciplines gezamenlijk werken. Op dit moment is het zo dat de doelen die worden gesteld veelal liggen op het vlak van de fysiotherapeut of de ergotherapeut. In de instrumenten die gebruikt worden, zoals de USER of de Barthel-index ontbreken meer verpleegkundige aandachtspunten als wondzorg en het zelfstandig beheren van medicatie. Door de focus op andere disciplines ervaren verpleegkundigen en verzorgenden dat hun bijdrage minder wordt gezien als revalidatiegericht. Het tweeledige karakter van het vak van verpleegkundigen en verzorgenden in de revalidatie speelt hierin ook mee. Cliënten die worden opgenomen in de geriatrische revalidatie hebben in deze post-acute fase vaak onderliggend (extra complicerend) lijden waardoor ‘zorgen voor’ en ‘verplegen’ prioriteit moet krijgen boven ondersteunen bij revalidatie (cliënt komt revalideren na sepsis en heeft decubitus na IC-opname; cliënt komt revalideren na oncologisch behandeltraject, moet leren omgaan met beperkte energie; cliënt komt revalideren met een nieuwe knie, heeft flink delier meegemaakt in het ziekenhuis). Dit is de consoliderende functie die Marit Kirkevold beschreef. Voor de verpleegkundigen en verzorgenden betekent het dat zij constant moeten switchen in attitude tussen revaliderend werken met de handen op de rug of juist ‘zorgen voor’. Aandacht voor continuïteit is vanwege dat tweeledige karakter belangrijk. Als er niet wordt gewerkt met een vorm van patiënttoewijzing, bestaat het gevaar dat enerzijds de te zieke cliënt ervaart dat hij onvoldoende ondersteund wordt (er wordt met de handen op de rug gewerkt) en anderzijds dat de cliënt die moet worden uitgedaagd om meer zelf te doen, nog teveel wordt verzorgd. Uit de focusgroepinterviews kwam ook naar voren dat methodiek type 3 het beste past bij de behoeftes van de cliënt. De tastbare oefendoelen geven grip op revalidatie, werken motiverend, zijn een aanvulling op de therapie, geven informatie aan mantelzorg en zorgen voor eenduidig werken door alle professionals.

ONDERZOEK IN DE PRAKTIJK NAAR WERKEN MET DOELEN

Parallel aan deze drie studies is er samen met een team op een geriatrische revalidatie afdeling onderzocht hoe het werken met revalidatiedoelen kan worden verbeterd, met als doel dat dit het revalidatieproces cliëntgericht zou maken. De afdeling was een Leer- en innovatienetwerk (LIN). Dit is een afdeling waar meerdere HBO-V studenten stage lopen. De leeractiviteiten die normaal voor de stagiaires op school plaatsvinden, vinden op de afdeling plaats samen met medewerkers. Daarnaast werken studenten en medewerkers samen aan kwaliteitsprojecten, in dit geval projecten die te maken hadden met het werken met cliënten met revalidatiedoelen. We volgden hierin deze gedachtenlijn: het werken met doelen is een manier om cliënten goed bij hun eigen revalidatietraject te betrekken. Door regelmatig de doelen te bespreken (waarom bent

u hier, wat is nodig om weer naar huis te kunnen, waar werkt u aan, hoe gaat dat, wat zit dwars? etc.) bevorder je die betrokkenheid op twee manieren. Ten eerste wordt het voor cliënten duidelijk wat de bedoeling is van het verblijf op deze afdeling en ten tweede door de voortdurende gesprekken over de doelen, krijgen cliënten de gelegenheid om te verduidelijken wat voor hen belangrijk is, waar zij dus aan willen werken en waar hun specifieke angsten of vraagstukken liggen. Met dit laatste wordt het revalidatietraject echt cliëntgericht. De veronderstelling van deze werkwijze is dat een cliëntgericht revalidatietraject de motivatie om te oefenen verhoogt.

MET DE CLIËNT HET MULTIDISCIPLINAIR OVERLEG VOORBEREIDEN

Op basis van bovenstaande gedachtegang hebben we twee experimenten uitgevoerd op de afdeling. Allereerst gingen de verpleegkundigen en verzorgenden het multidisciplinair overleg (MDO) met de cliënt voorbereiden. Tijdens het MDO wordt gekeken wat de stand van zaken is wat betreft de voortgang van de revalidatie. Door dit overleg samen met cliënten voor te bereiden, ontstaat er bij de verpleging een preciezer beeld van die voortgang. Daarnaast kan het gesprek eraan bijdragen dat cliënten zich meer bewust wordt van het traject waarin zij zitten, en wat hen nog te doen staat voordat naar huis gaan mogelijk is. Uit evaluaties bleek dat het eerste inderdaad het geval was: verpleegkundigen en verzorgenden zaten beter geïnformeerd in het multidisciplinair overleg. Zij konden de cliënt daar beter vertegenwoordigen, diens zorgen en specifieke vragen inbrengen. Daarnaast werd het voorbereiden van het MDO ook aangegrepen om het revalidatieplan te actualiseren. Dit zorgde voor meer continuïteit binnen het revalidatieteam: een actueel revalidatieplan zorgt ervoor dat iedereen met de cliënt aan dezelfde doelen werkt. Uit de evaluaties bleek ook dat de cliënten de gesprekken over het algemeen als prettig ervaren hebben: als een vorm van aandacht voor hen als persoon. Ook vonden ze het fijn om zorgen te kunnen delen. De gesprekken droegen er echter niet merkbaar aan bij dat cliënten een beter beeld kregen van het eigen revalidatietraject en bijvoorbeeld gemotiveerder gingen oefenen.

OEFENDOELEN OP HET WHITEBOARD IN DE KAMER VAN DE CLIËNT

Intussen was de vraag hoe het ons zou lukken om met behulp van het werken met revalidatiedoelen de cliënten beter bij hun traject te betrekken nog niet beantwoord. Daarom hebben de verpleegkundigen, de verzorgenden en de HBO-V-studenten samen met een aantal cliënten uitgetoetst of het werken met kleine meer dagelijkse of wekelijkse oefendoelen wél zou leiden tot meer betrokkenheid. Met een negental cliënten werden door middel van gezamenlijke besluitvorming oefendoelen bepaald om op het whiteboard in de eigen kamer te zetten. Bij alle negen cliënten had dit een bijzonder positief effect op de betrokkenheid bij het eigen revalidatieproces. Maar de manier waarop het positief werkte, bleek per persoon verschillend te zijn. Een voorbeeld maakt dit duidelijk. Stel het oefendoel dat de cliënt en de medewerker afspraken was om drie maal de afdelingsgang op en neer te lopen. Voor de ene cliënt werkte dit als een minimum: *ik zal laten zien dat ik dit ook vijf keer kan!* Voor

een andere cliënt als absoluut maximum: *twee keer is ook genoeg, morgen weer een dag*. Weer een andere cliënt was zelf al gedisciplineerd bezig met oefenen en had het whiteboard hiervoor niet nodig. Maar het gesprek over de vraag wat er voor deze dag op het whiteboard kon worden gezet, werd door deze cliënt gewaardeerd, de aandacht werkte motiverend. En weer een andere cliënt wilde het liefst zo weinig mogelijk bemoeienis van anderen. De afspraak die op het whiteboard werd gezet, gaf hem de prettige zekerheid dat niemand hem lastig zou vallen met vragen als: *weet u nog dat u vandaag drie keer de gang op en neer zou lopen?* We leerden hiervan dat de manier van ondersteunen per cliënt verschilt, en dat cliëntgericht werken ook inhoudt dat je als verpleegkundige rekening houdt met persoonlijke eigenschappen of de identiteit van de client. Een onverwacht gevolg van het werken met doelen op het whiteboard was dat de verpleegkundigen en verzorgenden meer kennis kregen over het werk van andere disciplines, zoals bijvoorbeeld de logopedist en de ergotherapeut als het bijvoorbeeld ging om energiemangement. Hierdoor groeiden zij zowel in hun revalidatie-expertise als in hun rol als verbinder tussen al die disciplines.

REFLECTIE: AANBEVELINGEN VOOR DE PRAKTIJK EN HET ONDERWIJS

Uit de vier genoemde studies kwam naar voren dat verpleegkundigen en verzorgenden in de geriatrische revalidatie voor de oudere een belangrijke verbindende rol kunnen spelen tussen het multidisciplinaire team en de revaliderende cliënt. Belangrijke voorwaarden voor het innemen van deze rol zijn interprofessionele samenwerking en continuïteit van zorg. Als deze factoren niet optimaal zijn, is dat van invloed op de kwaliteit van de informatie-uitwisseling over de voortgang van de revalidatie, zowel tussen de verpleegkundigen en verzorgenden en de revalidant, als tussen de verpleegkundigen en verzorgenden en de andere professionals in het multidisciplinaire team.

Om te beginnen horen verpleegkundige aandachtspunten deel uit te maken van de gezamenlijke anamnese. Als deze anamnese zich voornamelijk focust op doelen vanuit bijvoorbeeld de fysiotherapeut, dan kunnen verpleegkundigen en verzorgenden zich minder onderdeel voelen van het revalidatieteam. Ten tweede horen werkprocessen en methodieken het structureel voeren van gesprekken over de voortgang op doelen tussen de revalidant en de verpleegkundige of verzorgende te faciliteren, met het oog op een zo persoonlijk mogelijk revalidatietraject. Als derde zal continuïteit in de vorm van cliënttoewijzing de kwaliteit van deze gesprekken ten goede komen. Het werken met overkoepelende cliëntgerichte doelen en stelt verpleegkundigen en verzorgenden beter in staat een coördinerende rol te spelen op het hele revalidatieplan. Daarnaast schept het voor de oudere meer duidelijkheid. Ten vierde moeten verpleegkundigen en verzorgenden ook in staat worden gesteld het MDO bij te wonen voor hún specifieke cliënten. Deelname aan deze formele overleggen bevordert de informele samenwerking met de overige disciplines. Bovenstaande punten wijzen erop dat organisaties die geriatrische revalidatie bieden, een visie dienen te hebben op de rol die de verpleegkundigen en verzorgenden spelen in het multidisciplinaire team. Een visie uitgewerkt in functie

omschrijvingen, roldefinities en werkprocedures schept duidelijkheid over en geeft sturing aan verantwoordelijkheden. Het is een voorwaarde voor het daadwerkelijk innemen van die rol als een verbindende partner in het multidisciplinaire team.

Uit de verschillende onderzoeken komt verder naar voren dat verpleegkundigen en verzorgenden werkzaam in de geriatrische revalidatie een vervolgopleiding dienen te volgen in de geriatrische revalidatie. Onderdeel van die opleiding moet zijn het gestructureerd ondersteunen van de cliënt in het werken aan revalidatiedoelen. De belangrijkste elementen zijn: elke dienst weten van je cliënten aan welke doelen zij werken, met de cliënt praten over doelen, deze verbinden met het persoonlijke leven, stimuleren van het werken aan oefendoelen, evalueren van de voortgang op doelen, vragen welke zorgen het werken aan doelen in de weg staan, voortgang en zorgen goed vastleggen in het elektronisch cliëntendossier, enzovoort. Ook de complexe interactievaardigheden die nodig zijn om met oudere cliënten aan revalidatiedoelen te werken moeten onderdeel uitmaken van de opleidingen: vaardig worden in motiverende gespreksvoering en je tegelijkertijd bewust te zijn van de behoefte aan ondersteuning van de oudere cliënt en hiernaar cliëntgericht handelen. Ook het goed betrekken van familie van de cliënt, kwam naar voren als een aspect dat aandacht moet krijgen in zowel interventies als onderwijs.

VERPLEEGKUNDIGEN EN VERZORGENDEN BETREKKEN BIJ PARTICIPATIEF ACTIEONDERZOEK

Het onderzoek op de geriatrische revalidatie-afdeling was een participatief actieonderzoek. Deze vorm van onderzoek is gericht op het veranderen van de situatie, vandaar het woord *actie*. Het woord *participatie* wil zeggen dat het onderzoek wordt uitgevoerd samen met betrokkenen in de situatie waarover het onderzoek gaat. De visie achter deze vorm van onderzoek is dat de mensen in de situatie, in ons geval dus verpleegkundigen en verzorgenden, het allerbeste weten wat er goed en minder goed loopt. Zij kunnen goed beoordelen wat er verbeterd zou moeten worden. Als gevolg daarvan zal het daadwerkelijk veranderen van de situatie ook beter gaan, omdat de verpleegkundigen en verzorgenden vanaf het begin betrokken zijn. Ook is de gedachte dat deze manier van werken bijdraagt aan de professionele ontwikkeling van de verpleegkundigen en verzorgenden. Door naast de directe cliëntenzorg ook bezig te zijn met de processen in hun werk, maken ze kennis met andersoortige werkzaamheden en verbreden zij ook hun netwerk, bijvoorbeeld door te spreken met experts of door op andere afdelingen te gaan kijken hoe zij zaken aanpakken. Deze verbreding en verdieping van het werk zou wel eens kunnen bijdragen aan het behouden van verpleegkundigen en verzorgenden voor het beroep.

BELEMMERENDE EN BEVORDERENDE FACTOREN

Na afloop van het participatief-actie onderzoek zijn evaluatiegesprekken gevoerd en logboek aantekeningen over het onderzoek geanalyseerd, om te bepalen hoe het

gelukt was om verpleegkundigen en verzorgenden te betrekken bij het participatief actieonderzoek. Uit de evaluatiegesprekken bleek dat het Leer- en innovatienetwerk (LIN) aan die betrokkenheid een belangrijke bijdrage heeft geleverd. In het LIN werd iedere woensdag tijd om met elkaar te reflecteren, plannen te maken, ervaringen uit te wisselen en te leren. De teamleider speelde hierin een belangrijke faciliterende rol, zowel qua bezetting en tijd, als qua leerklimaat. Al met al ontstond er een positieve sfeer rondom de LIN en de woensdag. Medewerkers vroegen om op woensdag te worden ingepland. Belemmerende factoren waren er ook: in de eerste plaats de vele wisselingen in het team. Deze werden onder andere veroorzaakt door de Covid-pandemie, waardoor ambitieuze medewerkers gingen werken op de Covid-afdelingen. Daarnaast was er sprake van een samenvoeging van twee teams. Maar ook persoonlijke redenen speelden mee met het verloop, medewerkers vonden (bijvoorbeeld na hun interne opleiding) een andere werkplek, of waren afwezig vanwege ziekte of zwangerschap. Ook de studenten wisselden na twintig weken. Acties waren nodig om de rode draad in het proces voor iedereen steeds actueel te houden: het verbeteren van het werken met revalidatiedoelen. Dit doel kwam terug in alle bijeenkomsten, flappen van bijeenkomsten bleven hangen in de teamkamer en een nieuwsbrief werd gestart. Een andere belemmerende factor was het ontbreken van een kwaliteitsstructuur waarbij medewerkers van de afdeling actief betrokken waren bij kwaliteitsontwikkeling. Dit had kunnen bijdragen aan een meer duurzaam resultaat van het participatief actieonderzoek. Op het moment van het onderzoek was er nog weinig verbinding tussen de initiatieven op de afdeling en het overkoepelende kwaliteitsbeleid. Er was bijvoorbeeld nog geen jaarplan met doelen die voortkwamen uit signalen van medewerkers, of waarin medewerkers een duidelijke rol hadden bij de uitvoering. Ook maakte het systematisch werken aan kwaliteitsdoelen geen onderdeel uit van het dagelijks werk. Op dit vlak is er in de verpleeghuiswereld nog een wereld te winnen, want we hebben gezien dat medewerkers tot mooie verbeteringen in staat zijn, en ook dat het op die manier lerend en experimenterend bezig zijn veel plezier geeft. In het licht van de nieuwe wetgeving over zeggenschap van zorgmedewerkers is het interessant om te onderzoeken of het inzetten van participatief actieonderzoek als methode in zeggenschapsstructuren, een middel kan zijn om zeggenschap meer structureel en passend bij verpleegkundigen en verzorgenden vorm te geven.

CONCLUSIE

In de komende jaren zal het tekort aan verpleegkundigen en verzorgenden waarschijnlijk toenemen. Om uitstroom uit het beroep te voorkomen, is er meer aandacht nodig voor werkplezier. Werkplezier hangt samen met beroepsautonomie: de mate waarin je als beroepsbeoefenaar onafhankelijk en verantwoordelijk kunt handelen. Hiervoor is een duidelijk beroepsbeeld nodig: een gezamenlijk beeld van wat je rol is, waar je verantwoordelijk voor bent, wat anderen van je mogen verwachten. Het doel van dit proefschrift was om een bijdrage te leveren aan het verduidelijken van de rol van de geriatrisch revalidatie verpleegkundige en verzorgende. Het heeft aangetoond

dat verpleegkundigen en verzorgenden in de geriatrische revalidatie een cruciale verbindende rol kunnen spelen tussen de oudere revalidant en het multidisciplinaire team. Het continue gesprek met oudere revalidanten over de voortgang op doelen en het motiveren van deze ouderen om te werken aan doelen, helpt hen om grip te houden of krijgen op het eigen revalidatieproces. Hierdoor krijgt het revalideren betekenis voor hun dagelijks leven, wat de motivatie om ermee aan de slag te gaan kan vergroten. Onderwijs in de geriatrische revalidatie, passende methodieken en steun van het management met een heldere visie op de waarde van de verpleging in het multidisciplinaire team, zijn nodig om deze rol verder te versterken en in te bedden in het dagelijkse werk. Uiteindelijk zal dit niet alleen resulteren in een cliëntgericht revalidatieproces, maar ook in meer voldoening in het werk van verpleegkundigen en verzorgenden, met als gevolg dat de uitstroom uit deze beroepen kan worden tegengegaan.

- 1 In dit proefschrift wordt geen onderscheid gemaakt tussen verpleegkundigen en verzorgenden werkzaam in de geriatrische revalidatie. Waar verpleegkundigen worden genoemd, worden ook verzorgenden bedoeld. Hiervoor zijn twee redenen. Allereerst is in dit onderzoek gebruik gemaakt van internationale literatuur. De Nederlandse indeling in de niveaus verzorgende-IG, verpleegkundige niveau 4 en HBO-verpleegkundige is niet goed internationaal vergelijkbaar. De Nederlandse verzorgende-IG heeft bijvoorbeeld een langere theoretische opleiding gevolgd dan de Amerikaanse certified nursing assistant of licensed practical nurse. Ten tweede werken in de geriatrische revalidatie zowel verzorgenden-IG, verpleegkundigen niveau 4 als HBO-verpleegkundigen. Landelijk bestaan er geen richtlijnen voor de geriatrische revalidatie waarin functiedifferentiatie tussen deze drie groepen is uitgewerkt. Daarnaast bleek in de praktijk dat takenpakketten niet altijd scherp van elkaar te onderscheiden zijn: binnen teams werken deze beroepsgroepen nauw samen, nemen zij soortgelijke zorgtaken op zich en vullen zij elkaar flexibel aan. Om die reden is ervoor gekozen om de bevindingen op een meer overkoepelend niveau te presenteren. De sector is zich aan het professionaliseren, welk niveau functionarissen daarin nodig is, of welke mix, is een vraag die nog beantwoord moet worden.
- 2 Kirkevold M. The role of nursing in the rehabilitation of stroke survivors: An extended theoretical account. *ANS. Advances in nursing science*. 2010;33(1):E27-E40.

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Als het gaat om professionaliseren van het beroep, lag bij Sting de nadruk op de beroepsinhoud. Bij Verpleegkundigen en Verzorgenden Nederland leerde ik van mijn collega's van Verenigingszaken hoe gespecialiseerde verpleegkundigen en verzorgenden in verenigingsverband samen werken aan een stevige beroepsidentiteit.

In het kader van dit promotietraject mocht ik een bijdrage leveren aan de professionalisering van het beroep van verpleegkundige en verzorgende in de geriatrische revalidatie. Ik deed dit onder andere als onderzoeker en lecturer practitioner in verpleeghuis Hof van Sloten. Voor de mogelijkheid die ik kreeg om onderzoek te doen met het team verpleegkundigen en verzorgenden, wil ik het management en de medewerkers van Cordaan hartelijk danken. Met het team en de stagiaires van eerst A0 en daarna A1 onder leiding van Herleen Brama onderzochten we het werken met doelen. De woensdag was al die jaren mijn favoriete dag van de week: met medewerkers en studenten reflecteren over het werken op een geriatrische

revalidatie-afdeling, nieuw gedrag uitproberen, je voortdurend aanpassen aan de cliënt met wie je samenwerkt. Voor al die mooie en leerzame gesprekken wil ik het team en de studenten bedanken. Herleen en ik waren trots op het team: *Het is geen wedstrijd, maar we hebben wel gewonnen!* was onze leus. Ik voelde me welkom en deel van het team. Jullie maken mooie dingen mee met de cliënten, vaak bijzondere Amsterdamse paradijsvogels uit allerlei culturen. Ik heb ook bewondering voor jullie flexibiliteit. Tijdens het onderzoek brak Corona uit, met de bekende gevolgen voor de ouderen en de medewerkers in het verpleeghuis: het verbod op bezoek, het gebrek aan beschermende middelen. Daarna moest het team verhuizen én fuseren met een ander team én er volgde een verbouwing. Het is een wonder dat we zoveel met elkaar hebben kunnen onderzoeken en uitproberen. Maar het team bleef staande, creatief en flexibel. Tijdens Corona, toen ook ik niet meer op de afdeling mocht komen, stelde verpleegkundige Natasja Collewyn voor dat ik buiten voor het open raam kwam staan. In die prachtige lente van 2020 hield ik zo contact met het team. Ik twijfelde of we door moesten gaan: er was zoveel aan de hand. Maar het team gaf aan: *Ja juist! Het leidt ons af van Corona*. Al in dat eerste semester bleek hoeveel energie het gaf om over het werk en de stage-ervaringen uit te wisselen. Dat bleef gedurende het hele onderzoek. Wat ik leerde bij Sting bleek waar: met elkaar reflecteren over het werk is een krachtig kwaliteitsinstrument.

Marjolein Albers, jij was mijn promotiemaatje. Op de 7^e verdieping keken we elke vrijdag uit over Amsterdam en het Binnen-IJ. Het begon op te vallen dat er wel erg vaak boten voorbij voeren die *De Volharding* heetten. Ook *De Vlijt*, *Voorwaarts* en *Inspiratio* voeren voorbij. Maar ook *Insomnia*... uiteindelijk was daar *Felicitas*! Superfijn om dit traject samen met jou te doorlopen. Promoveren bracht niet altijd het beste in me naar boven. Dat jij die worstelingen herkende, was goud waard en relativerend. Ik zal jou ook steunen tot het einde.

Privé heb ik veel belangstelling en aanmoediging gehad. (Schoon)familie, buur-, brei-, kerk-, toneel-, zwemvrienden en -vriendinnen, dank jullie wel!

Straks bij de verdediging staan er twee mensen naast me, Petra Cornelissen en Martie Fleuren. Petra, leren is een vast thema in onze vriendschap, ik bel jou als ik me afvraag hoe iets werkt in ons vak, jij spart met mij als je een opdracht voor een opleiding moet maken en jij hebt altijd veel belangstelling voor waar ik mee bezig ben als onderzoeker. Ook hoe verder leren wel of niet past in ons leven is een regelmatig een onderwerp. In de aanloop naar de feestelijke dag ben ik ontzettend blij met een positieve en daadkrachtige lieverd naast me, dat ben jij Martie, dank jullie wel dat jullie mijn paranimfen wilden zijn.

Mijn ouders, Marie en Theo Vaalburg, zouden nu respectievelijk 101 en 98 zijn geweest, als ik mijn ogen dicht doe, zie ik ze stralen op de eerste rij. De promotie vier ik graag

met Bob en Renée, grote broer, die mij vanuit zijn studentenkamer per brief op pad stuurde om in de buurt onderzoekjes te doen, is het daar begonnen? En lieve, altijd belangstellende schoonzus, en grote steun in de laatste fase.

Paul, Jules, Martie, Broos en Madelief, als laatste dank ik jullie. Dat ons gezin voor een groot deel bestaat uit steigerbouwers, heeft ervoor gezorgd dat ik niet ben ingestort!

Anne Marie Vaalburg

PHD PORTFOLIO

COURSES

- Qualitative Research Methods in Health Care: basic course. University of Antwerp 2019
- Research integrity, VUmc Academie 2019
- Participatory Learning & Action (PLA) Research. Pharos Utrecht, 2019
- Participatief Actieonderzoek: de waarde van PAO bij innovatie van zorg. Inholland Incompany training door dr. F. van Lieshout, 2021
- Writing a scientific article. Taalcentrum VU, 2021
- Kwalitatief onderzoek: verdieping. EpidM Amsterdam UMC, 2022

(INTER)NATIONAL CONFERENCES

- Geriatriedagen 2022, Online workshop
- International Association for Gerontology and Geriatrics 2022
Poster presentation
- Amsterdam Public Health Annual Meeting 2022, Poster presentation
- 23rd International Conference on Integrated Care (ICIC23) Antwerp
Paper presentation
- Mini-symposium Samen Leren in de GRZ, Inholland, Cordaan, Amsta, ZHGA, Amsterdam 2023, Key note
- Jaarcongres GRZ, Utrecht 2024, Breakout sessie
- V&VN Geriatriedag, Nijkerk, 2024, Oral presentation
- European Geriatric Medicine Society (EuGMS), Valencia, 2024
Poster presentation
- Symposium Een zonnige toekomst voor de geriatrische revalidatiezorg: Succesvolle toepassingen van het uitdagend revalidatieklimaat, De Zorgboog & September, Eindhoven, 2024, Workshop
- Cordaan Specialistische Zorg voor Ouderen Symposium Samen op stap: op ontdekkingsreis in ons eigen domein! Amsterdam, 2024, Key note
- Universitair Netwerk Ouderenzorg (UNO) Symposium, Amsterdam, 2025
Key note

TEACHING

Several educational courses on research skills (onderzoekend vermogen), Inholland University of Applied Sciences.

PUBLICATIONS

Vaalburg AM, Wattel E, Boersma P, Hertogh C, Gobbens RJJ. Goal-setting in geriatric rehabilitation: Can the nursing profession meet patients' needs? A narrative review. *Nursing Forum*. 2021;56(3):648–659.

Vaalburg AM, Boersma P, Wattel EM, Ket JC, Hertogh CM, Gobbens RJJ. Supporting older patients in working on rehabilitation goals: A scoping review of nursing interventions. *International journal of older people nursing*. 2023;18(4):e12542.

Vaalburg AM, Wattel EM, Boersma P, Hertogh CM, Gobbens RJJ. The role of nursing staff regarding goal setting and achieving in geriatric rehabilitation: A focus group study. *Rehabilitation Nursing Journal*. 2023;48(5):148–159.

Vaalburg AM, Boersma P, Wattel EM, Hertogh CPM, Gobbens RJJ. Involving nurses in participatory action research: Facilitators and barriers. *Journal of Participatory Research Methods*. 2024;5(3).

Vaalburg AM, Wattel EM, Boersma P, Hertogh CPM, Gobbens RJJ. Participatory Action Research to Enhance Patient-Centred Goal Setting in Geriatric Rehabilitation: A Nursing Team's Quest. *Journal of Advanced Nursing*. 2025;0:1–19.

Vaalburg AM, Wattel EM, Boersma P, Hertogh CM, Gobbens RJJ. De rol van verpleegkundigen en verzorgenden bij het opstellen en werken aan doelen in de geriatrische revalidatie: een focusgroepstudie. *Verpleegkunde*. 2024;39(4):153-164.

ABOUT THE AUTHOR

Anne Marie Vaalburg studied nursing at de Hogeschool van Arnhem en Nijmegen. After working as a nurse for several years, she obtained a master's degree in Policy and Organization of Healthcare at Utrecht University. She then worked at several organisations focused on healthcare quality from both patient and professional perspectives, including the Trimbos Institute for Mental Health; Vilans, the national center of expertise for long-term care; the Dutch Patients' Federation (PFN); the Dutch Multiple Sclerosis Association (MSVN); Sting, the professional association for certified nursing assistants; and V&VN, the Dutch Nurses' Association.

In 2019, Anne Marie began her PhD research at the Department of Medicine for Older People at Amsterdam UMC, VU Medical Center. At the same time, she joined the Health & Well-being of Frail Older Adults research group led by Professor Robbert Gobbens at Inholland University of Applied Sciences. She combined her PhD research with teaching in the Bachelor of Nursing program at Inholland University of Applied Sciences. She will continue working as a researcher and lecturer, with a focus on older adults in both roles.



De komende jaren zal het tekort aan verpleegkundigen en verzorgenden waarschijnlijk toenemen. Om uitstroom te voorkomen, is meer aandacht voor werkplezier nodig. Werkplezier hangt samen met beroepsautonomie: de ruimte om zelfstandig en verantwoordelijk te handelen. Dat vraagt om een duidelijk beroepsbeeld: een gezamenlijk beeld van wat je rol is, waar je verantwoordelijk voor bent, wat anderen van je mogen verwachten.

In dit Engelstalige proefschrift beschrijft Anne Marie Vaalburg haar zoektocht, samen met geriatisch revalidatieverpleegkundigen en verzorgenden, naar hun rol. De onderzoeken tonen aan dat zij een verbindende rol kunnen spelen tussen de oudere revalidant en het multidisciplinaire team. Door voortdurend in gesprek te blijven over doelen en voortgang, helpen zij ouderen grip te krijgen op hun revalidatieproces.

Onderwijs in de geriatische revalidatie, passende methodieken en steun van het management met een heldere visie op de waarde van de verpleging in het multidisciplinaire team, zijn nodig om deze rol verder te versterken en in te bedden in het dagelijkse werk. Uiteindelijk kan dit bijdragen aan een cliëntgericht revalidatieproces, maar ook aan meer voldoening in het werk van verpleegkundigen en verzorgenden, wat van belang is om de uitstroom uit deze beroepen tegen te gaan.