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Family members’ expectations regarding nurses’ competence in care homes: a qualitative interview study

**Running title:** nurses’ competence in care homes

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**Conflict of interest:**
The authors declare no conflict of interest.
Abstract:

**Background:** Structural and cultural changes in the care of older people have influenced nursing practice, creating a need to identify current competence requirements for nurses working in care homes. Family members have an important role in ensuring the well-being of older people living in care homes, and family members’ can provide valuable information about competence requirements.

**Aim:** To explore the expectations of the care home residents’ family members regarding the competence of nurses in care homes for older people.

**Methods:** A qualitative descriptive design was used. Semi-structured interviews were conducted with 18 care home residents’ family members between March and September 2016. Participants were recruited with help from regional associations and member associations of The Central Association of Carers in Finland and from regional associations of The Alzheimer’s Society of Finland. The snowball technique was also used. The data were analysed using inductive content analysis.

**Ethics:** Ethics committee approval was obtained from the university committee on research ethics, and written informed consent was obtained from participants.

**Findings:** The care home residents’ family members expected that nurses would be able to interact with and treat people respectfully. Reflective collaboration between the nurse and a family member was also emphasized. Family members expected nurses to provide high-quality basic care and nursing and support residents’ well-being individually and holistically.

**Conclusions:** Family members’ expectations reflect the need for ethical and interactional competence in the care home. In addition, evidence-based practice competencies are required to provide high-quality care. Nurses’ ability to provide person-centred, individual and holistic care is vital to ensure care home residents’ well-being.

**Keywords:**
care home, competence, family member, nurses, nursing, older people
INTRODUCTION
Structural and cultural changes in the care of older people have influenced nursing practice (1), and comprehensive competence is required of nurses working in long-term care facilities for older people (2). Nursing staff competence influences residents’ and family members’ satisfaction with the care provided in long-term care facilities (3). Competence is composed of knowledge, skills and other components, which include attitudes and values (4). While exploring the competencies required of nurses working in care homes, it is essential to listen to various stakeholders. Because family members have an important role in long-term care, particularly in ensuring the well-being of older people with dementia (5, 6), their views regarding care of older people must be considered.

Background
It is essential to become aware of current competence demands in care homes to ensure the well-being of the older people living in these units. No empirical research with the aim of exploring the expectations of care home residents’ family members regarding nursing competence has been published. However, there are other empirical studies that reflect family members’ expectations in care and nursing home context. Family members expect nurses to treat people with respect, perceive residents as human beings (7, 8, 9, 10), and respect the residents’ autonomy as much as possible (11). Nurse-resident relationships and dialogue between staff and family require interactional competence (7, 9-13). According to family members, being a good colleague to other staff members and being able to create a positive atmosphere in a nursing home are characteristics of qualified staff (11). Supporting the residents’ social contacts and participation, providing opportunities for activities inside and outside the nursing home (7, 9, 11), and nurses’ emotional support for families (14) are valued.

Family members expect nurses to take good care of the older person’s basic needs, such as hygiene and appropriate clothing (7, 9, 11, 14, 15). Maintenance of the older person’s physical abilities for as long as possible and ensuring residents’ safety are also essential (7, 14). Skilled nurses are knowledgeable regarding memory disorders and are able to manage challenging situations (9). Nurses’ ability to prioritize and their ability to endure criticism and complaints are also valued by family members in nursing homes (7).

Previous studies reflecting care home residents’ family members expectations have focused on specific aspects of care, for example, staff-family relationships (12), family-centered care
(14) and ethical aspects of care (8-10). However, none of the studies have reported care home residents’ family members expectations regarding nurses’ competence in their entirety.

AIM
The aim of this study was to explore expectations of the care home residents’ family members regarding the competence of nurses in care homes. The following research question was addressed: What type of competence do care home residents’ family members expect of nurses working in care homes?

METHODS
Study design
A qualitative descriptive design with semi-structured interviews was used in this study. The semi-structured interviews enable participants to talk freely about issues that are important to them.

Setting
Ensuring quality of care for older people living in care and nursing homes is the subject of ongoing debate around the world. This study was conducted in Finland, where deinstitutionalization is a substantial trend in the redesign of long-term eldercare. Long-term care is primarily provided at home or, if residential care is necessary, in intensive service housing (16) (also known as intensive sheltered housing). As a result of this trend, the most dependent and frail older people enter intensive service housing units; multimorbidity and cognitive impairment are common. Intensive service housing units offer 24-hour assistance and care in homelike environments; both short-term care and long-term care are provided. For example, licensed practical nurses, registered nurses and care assistants work in these units. There is national guidance on staff accountability, duties and task allocation related to the provision of pharmacotherapy in social and health care (17); otherwise, the legislation in Finland allows a great deal of latitude for these units to define duties and allocate tasks in these units. Intensive service housing units are often informally called “nursing homes” or “care homes”, and in this paper, we have used the term “care home” to refer to these units.

Recruitment and data collection
Care home residents’ family members were recruited with help from regional associations and member associations of The Central Association of Carers in Finland (n=11) and from regional associations of The Alzheimer’s Society of Finland (n=4). The first author sent e-
mails with an information sheet to the associations, and the contact persons there informed people about this study in various manners. The researcher also attended one association meeting and explained the study to the attendees. Family members willing to participate in the study were requested to contact the researcher via e-mail or phone. The snowball technique was also used (n=3) for recruitment: a person willing to participate in the study (not a member of the association) recommended additional participants. Family members whose loved ones were living in a care home or had had interval periods in a care home were invited to participate in the study. However, no interval period clients’ family members participated in the actual sample. A family member was defined as a person who plays a significant role in an individual’s life. It was decided that an adequate number of informants had been achieved when new categories no longer arose from the interviews (18).

One focus group interview with six participants and 12 individual interviews were conducted between March and September 2016 by the first author. Individual interviews ranged in duration from 30 minutes to 1 hour and 23 minutes, and the duration of the focus group interview was 1 hour and 15 minutes. Three interviews were conducted in meeting places for associations whereas others (n=10) were conducted at participants’ homes. No one else was present during the interviews besides the participant(s) and the researcher. People who participated in the focus group interview were members of the Association of Carers. Those members had regular meetings and knew one another well, so they wished to be interviewed together.

The interview guide containing interview themes was pilot tested with two family members, and the research group discussed those interviews together. There was no need to revise the interview guide, and pilot interviews were included in the data. The themes in the interview guide were related to family members’ expectations regarding nurses’ competence in care homes, and the primary themes were pre-expectations and current expectations. To help participants express their expectations, family members were requested, for example, to describe what makes a competent nurse and to describe situations in which their expectations had been met or had not been met. The interview guide is presented in Table 1. All interviews were audiotaped and transcribed verbatim.

Data analysis
The data were analysed manually using the inductive content analysis method. Inductive content analysis was used because there were no previous studies addressing family members’
expectations regarding nurses’ competence in care homes (19). The text of each interview was divided into meaning units based on the manifest content of the phenomena revealed (20). Meaning units were words, sentences and portions of sentences containing aspects related to one another. Units were condensed, and condensed meanings were grouped together into subcategories and then into upper categories and primary categories. Data analyses were conducted concurrently with data collection; preliminary analysis began after three interviews (21). It helped to recognize when new categories no longer arose from the interviews and when the saturation seemed to have achieved.

**Rigour**

We judged the trustworthiness of the research process by its credibility, dependability, and transferability (20). To increase the credibility of the results, the participants were recruited from different sections of the country. In addition, all categories were compared to the original data to ensure that the data represented the information that the family members provided. The researchers maintained an open dialogue during the entire research process to increase dependability. The transferability of the results was facilitated by clearly describing context, the selection and characteristics of participants, data collection and the analytic process. (20)

**Ethical considerations**

The University of Eastern Finland Committee on Research Ethics (statement 8/2015) gave a favorable opinion of this research, and written informed consent was obtained from participants. Participants were informed of their right to withdraw from the study at any time without explanation or consequence and were given assured that their participation would not affect the care provided for their loved ones. Confidentiality was guaranteed by substituting identification numbers for participants’ names on study records and files and by deleting all names during transcription. Some participants exhibited signs of distress during the interview, particularly when describing situations in which their expectations had not been met. However, none of the participants wanted to interrupt the interview. Interviewees reported thinking about these issues often before even knowing about the study and were pleased to have the opportunity to express their views.

**FINDINGS**

Study participants (n=18) were from different sections of Finland. Their loved ones had been living in a care home from 4 months to 4.5 years. Care homes were categorized as intensive
service housing (non-institutional care), although one of the care homes officially provided institutional care at the time the interview was conducted. However, this facility differed from intensive service housing only in payment practices. Participants (n=18) ranged in age from 56 to 83 years (mean 70.5 years). Fifteen were retired and three were in a working life. One male and 17 females were spouses (n=13), adult daughters (n=3) and close friends (n=2) of care home residents. Many study participants visited the care home every day or nearly every day, and all participants visited at least once a week.

**Family members’ pre-expectations regarding nurses’ competence**

Family members’ pre-expectations -expectations they had before their loved one moved to the care home - were minor. Many of the interviewees had acted as primary caregivers and were exhausted by the time their loved one moved to the care home. Therefore, family members were relieved, although the loved one’s transition to a care home was emotionally difficult. Former caregivers expected to return to the role of a spouse. In addition, interviewees expected to be welcome at care home and that there would be professional staff. Participants also expected that their loved one’s individuality would be respected and that the well-being, health and functional capacity of the loved one would be maintained.

**Family members’ current expectations regarding nurses’ competence**

Four primary areas of competence were identified that describe family members’ expectations regarding nurses’ competence in care homes: (a) encountering and treating people respectfully, (b) reflective collaboration between the nurses and the older persons’ family members, (c) holistic and individualized promotion of the older person’s well-being, and (d) older person’s high-quality basic care and nursing. A summary of the categories and primary categories is presented in Figure 1.

*Encountering and treating people respectfully*

Care home residents’ family members expected that nurses are able to encounter people respectfully. Interviewees hoped that nurses would greet residents, family members and other visitors and be willing to listen and talk with people. According to family members, a competent nurse is able to be fully present when encountering an older person and able to read non-verbal communication. The ability to encounter an older person with a memory disorder was particularly emphasized. A family member reported:
My spouse’s primary nurse taught other nurses how to encounter my spouse… just every-day encounters in practical situations…And I brought something for the nurses to read… so they will read about how to treat a patient with a memory disorder. (Participant 5, spouse)

It is essential that residents are not ignored. According to family members, nurses should engage with and inform the older person when nurses are changing continence products or performing other procedures; nurses should not engage only with one another. One family member described the importance of the encounters in the following manner:
They might just walk past her as many as ten times. It’s always about making contact: saying hello, approaching, smiling. Not like, hey, I’ll just move you to the side, you’re in my way a little bit. (Participant 2, close friend)

Nurses were expected to treat people with respect. Interviewees described a competent nurse as warm and empathetic and able to perceive the older person as a human being, not only as a client. Participants expected nurses to treat both residents and co-workers properly, and not abuse their power. Nurses should always help residents when necessary. For example, all nurses should not take a lunch break simultaneously: however, if nurses are on break simultaneously, residents must nevertheless receive help without delay when necessary. In addition, nurses should not use baby talk in communicating with the residents but should treat residents calmly, kindly and gently.

Participants mentioned that nurses should act according to what is best for the resident and not what is easier for the nurse and that nurses should not discount an older person’s subjective experience based on the nurse’s own feelings or experiences. A nurse should believe an older person, for example, if that resident complains of pain. Conversely, interviewees also emphasized that nurses should not always believe what a resident with a memory disorder says. For example:
If you ask, do you need to go to the toilet, he will say, no I don’t. But when you take him to the toilet, he did need to go after all… You should observe people more. (Participant 9, close friend)

In addition, family members wished that nurses would respect the residents’ property. Nurses should take good care of the resident’s clothes and maintain the resident’s room (in which the resident has his/her own furniture) in good order.
Reflective collaboration between the nurses and the older persons’ family members

Nurses’ ability to collaborate with family members was considered basic, and nurses were expected to support the participation of the family members in numerous ways. Family members wished to be welcomed in the care home. Family members desired accurate information in response to their questions and wanted nurses to discuss the resident’s daily activities, condition, illnesses and care honestly and without being asked. The following quotation illustrates this desire:

Of course I would like to hear, whenever I drop by over there, to hear how he has been doing. You see, my spouse is unable to speak or say anything. (Participant 4, spouse)

Family members wanted nurses to receive feedback from family members and develop actions based on that feedback. Family members also mentioned that nurses should be able to welcome a family member like a volunteer worker if the family member is willing to function as a volunteer in the care home.

Many interviewees had feelings of guilt related to their loved one’s transition to a care home and emphasized the nurses’ willingness to support family members, particularly in the beginning when the resident has just moved to the care home. A family member stated: Nurses should support family members in the beginning. Like, they could say more directly that the situation is really like this, you simply wouldn’t have been able to cope with your spouse at home… that you have made the right decision. (Participant 17, spouse)

Holistic and individualized promotion of the older person’s well-being

Family members’ interviews revealed that care home residents’ well-being should be promoted holistically. Such a course of action includes all aspects of well-being. In addition to physical needs, residents’ social contacts as well as overall communality in a care home should be promoted. For example:

I would have wanted more of that, that the nurses and residents would have done something together. Drink coffee or… (Participant 10, adult daughter)

The nurses sometimes gather all the residents together and they have a singing session there… It’s the plus side in that facility: the nurses spend time with the residents. (Participant 18, adult daughter)

Family members appreciate nurses who create a positive atmosphere in the care home and
appreciate nurses who use humor in their daily work. Using humor is one manner in which a competent nurse addresses challenging situations with residents.

According to family members, nurses should provide opportunities for residents to enjoy recreational and outdoor activities. All residents should have this opportunity, not only residents in better physical condition. It is possible that volunteer workers, different visitors and others can offer these activities which are not necessarily always the nurses’ responsibility. However, nurses should at least have a positive attitude towards these activities and towards visitors in the care home. Nurses should, for example, ensure that seasonal holidays are celebrated in the care home. The importance of music emerged in all interviews. Music and singing was considered beneficial to older persons’ well-being in numerous ways. Singing was perceived not only as a recreational activity but also as a form of interaction.

Nurses were expected to recognize the resident’s individuality in every action. To do so requires knowledge of the older person’s life history, customs and habits. Family members were happy to see that a nurse was truly interested in their loved one’s likes and dislikes and was willing to use this information in practice. Interviewees appreciated nurses who were able to handle situations individually and were sufficiently flexible to adjust routines when necessary.

Another important principle in supporting the well-being of an older person is the encouraging of the older person’s participation. Interviewees did not use the term ‘participation’ but expected that nurses working in a care home should understand that the facility is a home for older people and that residents’ opinions should be carefully listened to and acknowledged. Interviewees expected nurses to identify the older person’s resources and utilize them. Participants emphasized the ability to recognize also the resources of an older person with a memory disorder.

*Older person’s high-quality basic care and nursing*

Family members expected nurses to do their best to ensure the residents’ safety in the care home and that nurses would prevent dangerous situations and accidents. Vigilance and awareness of what is occurring, for example, while the nurse is performing housekeeping duties were expected. Safety expectations were related to the prevention of falls and the prevention of physical conflicts between residents. Interviewees also expected nurses to have food hygiene competence and competence in other areas of hygiene.
Good basic care, including the older person’s personal hygiene (e.g., sauna and showering), oral care, shaving, cutting nails, skin care, changing the bedridden resident’s position, toileting and changing diapers, was emphasized in interviews. In addition, recognizing the resident’s need for rest during the day was expectation. Families also expected nurses to assist an older person with eating and drinking whenever necessary and ensure a pleasant meal situation for the resident. This theme arose, for example, in the following excerpt:
They wait until his mouth is empty, they don’t just immediately stick in another spoonful before he has been able to swallow the first one. (Participant 7, spouse)

Interviewees wished that nurses would help residents remain active and rehabilitate the residents whenever possible, considering the older person’s health condition. Nurses were expected to assist residents in transfers (from the bed to wheelchair and vice versa) using a patient lift or without the lift, depending on the resident’s condition. Family members appreciated nurses who recommended and supplied suitable aids for the older person. For example:
The primary nurse said, now that I went there, that "We got a new wheelchair now”. It has a headrest and all, so he can rest against it. It has footrests too… Now he likes to go to the common room. (Participant 6, spouse)
My spouse had fallen and the nurse asked what I think, should we put hip protectors on him. I said, absolutely we should…And the nurse went to get this hip protector model. (Participant 8, spouse)

Family members expected nurses to observe the residents, for example, for possible symptoms of disease. In addition, the monitoring of chronic diseases was required. Nurses were expected to consider the resident’s visual and hearing impairments, and limitations caused by various diseases. The ability to prevent and manage challenging situations with an older person with a memory disorder was also emphasized. This ability requires knowledge regarding memory diseases but also knowledge regarding the older person’s customs, habits and life history.

An interviewee also emphasized the importance of documentation, noting that the doctor visits a care home only occasionally and that changes to residents’ medication are based on nurses’ telephone reports. The flow of information within the care home and between the care home and the hospital was also emphasized.
In addition, nurses were expected to conduct safe and appropriate pharmacological care. Nurses should address pain management and be able to provide hospice care. Also important were being able to discuss death, preparing family members for a loved one’s death, and communicating with family members of the deceased.

Although our goal in this study was not to explore family members’ perceptions of nurses’ level of competence, the interviews clearly revealed large variations in families’ perceptions of the degree to which the nurses fulfilled families’ expectations. The majority of the participants were satisfied or very satisfied with the nursing staff and the care provided in the care home. However, some interviewees expressed their deep dissatisfaction with nurses’ competence, and a few of them even worried about their loved one’s well-being. Although we explored expectations regarding nurses’ competence, family members emphasized having expectations in addition to the expectations related to nurses’ competence.

DISCUSSION
The findings of this study enhance our understanding of family members’ expectations regarding nurses’ competence in care homes. These insights can be utilized by care home nurses, managers, nurse educators and policy makers to develop the quality of care in care homes. According to this study, a holistic individual and person-centred approach is required of nurses in care homes. Family members’ expectations particularly highlight the need for ethical and interactional competence reflecting the nature of the care home context. Ethical dilemmas are common (10); the needs and rights of all residents must be considered equally, and residents are not necessarily able to defend their rights in care homes. Evidence-based practice competencies are also required to provide high-quality care for older people living in care homes.

Our findings emphasize nurses’ ability to interact with residents. This finding is consistent with Bollig et al. (10), in which nursing home residents’ relatives defined a good nurse a person who would see the resident and show that she cares. Previously have been shown that nurse-patient interaction has influence on nursing home patients’ hope, self-transcendence, meaning-in-life and quality of life (22, 23, 24); it is a vital resource for promoting well-being among nursing home patients (25). To be perceived as a human being and to be engaged in some type of social interaction are crucial factors for the well-being of an older person living
in a nursing home (10, 11). Situations in which nurses do not communicate with the residents while helping those residents are perceived as violations of dignity (8, 26).

Having a good collaboration with the nursing staff is important for family members, and nurses should pay attention to interaction with families. Listening to the families’ views is vital to the development of good staff-family relationships (12). Family members may feel more confident in expressing their wishes and concerns when nurses are kind and friendly (13). In addition, a study by van Hoof et al. (11) concluded that if relatives feel welcome, family members are inclined to visit the care home more often. In our study, family members reported feelings of guilt when they were not able to take care of their loved one at home anymore, which has also been reported in previous studies (10, 27). The person’s transition from home to a care home requires acceptance and adaptation both from residents and relatives (10), which should be noted by nurses.

In our study, the family members emphasized nurses’ ability to provide high-quality basic care. The importance of the “little” but significant things, such as hygiene or appropriate clothing, has also been highlighted, for example, in a study by Ryan and McKenna (15). Basic care is an important element of family members’ definition of “being cared for” (14). Our study revealed the need for evidence-based nursing. The ability to provide care for older people with memory disorders was particularly accentuated. Nurses ought to be aware of non-pharmacological approaches that are beneficial in supporting the well-being of people with dementia. For example, singing and music-listening activities have been shown to improve or maintain cognitive functioning, mood and the quality of life of persons with dementia (28). Information regarding the health benefits of music and how music can be used in the care of older people could be offered to student nurses and in continuing education.

It is essential to ensure that nurses working in care homes are able to meet the needs of older people. The quality of care affects both the resident and the family. Neglect is particularly upsetting for family members of people with memory disorders, because these family members know that their loved ones are not able to speak up for themselves (15). Perceived deficiencies in care are sources of stress for family members; relatives feel responsible for remaining vigilant to ensure better care (29). In these situations, it may not be possible for the family caregiver to transition from the role of a caregiver to the role of a spouse.
During the interviews, the family members emphasized expectations in addition to those regarding nurses’ competence; it is important to note the complexity of long-term care environments. Many contextual factors influence, for example, nurses’ use of knowledge in these facilities (30). Care is not only an act between a nurse and a resident, but context (such as physical environment, resources and leadership) also shape those acts (30).

**Limitations**

We acknowledge a few limitations to our study. First, the fact that the care home residents themselves were not involved in the study, may be perceived as a limitation. However, the family members who participated in this study visited their loved ones often, and thus were frequent observers of daily life in the care home and valuable informants. Second, the majority of the study participants were women who were engaged with the association, so the group was relatively homogenous, which might be seen as a limitation. Third, the transparency is rather weak. Interviews provided rich data and because the space is limited in the article, it was impossible to include many quotes from participants.

The study findings are transferable to Finnish care homes. The transferability of the results to care homes in other countries may vary, because, for example, the resident populations may vary among care homes in different countries. In Finland, care home residents are in great need of care; multimorbidity and cognitive impairment are common. The findings may be transferable to care homes with similar resident population. In addition, care facilities for older people are known by a diverse range of terms globally. There is ambiguity, for example, regarding the terms “nursing home” and “care home” (31). This type of resident population may be comparable to nursing home resident populations in other countries.

**CONCLUSION**

Family members’ expectations regarding nurses’ competence in care homes are multifaceted. To be able to enhance the quality of care in care homes, family members’ views should be considered when evaluating the nursing care of older people in care homes. Nurses should note the importance of respectful encounters and active interaction with residents and family members and nurse managers should particularly support nurses’ ethical competence in care homes in various ways. Nurse educators should ensure that graduating nursing students are able to holistically meet the needs of older people living in care homes. In addition, continuing education is necessary throughout a nurse’s career. It is important that policy
makers are aware that versatile competence and a well-educated nursing staff are necessary in care homes when deciding what type of education is required for nurses working in care homes. Of course, there is also room for volunteers and other visitors who do not have social-and health-care education but who can provide recreation and support the well-being of older people living in care homes.
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<td>Acquisition of aids</td>
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<td>Monitoring chronic diseases</td>
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<td>Considering diseases</td>
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<td>Hospice care</td>
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<td>Managing the flow of information</td>
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<td>Considering sensory impairments</td>
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<td>Preventing dangerous situations</td>
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<td>Maintaining the physical functional capacity</td>
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<tr>
<td>Preventing and managing challenging situations with an older person with a memory disorder</td>
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Figure 1 Family members’ expectations regarding the competence of nurses in care homes