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How do clients and (In)formal caregivers experience quality of home care? A qualitative approach

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Abstract

Aim: To explore and understand the views of clients and formal and informal caregivers about the experienced quality of home care for older people.

Design: A descriptive qualitative study was conducted using individual interviews.

Methods: Six home care clients, four formal and six informal caregivers were recruited from two Dutch home care organizations. Individual, semi-structured interviews took place between April - November 2018. The INDividually EXperienced QUAlity of Long-term care framework was used to guide data collection and content analyses.

Results: The analyses revealed several important attributes contributing to experienced quality of home care such as a preferred small number of caregivers, perceived sufficient time for care provision and a caring atmosphere facilitating open communication and humour. Participants indicated that care routines fitting with the care receiver's former way of living were important. A more 'close' personal care relationship related to trust, openness and empathy was preferred over a more 'detached' professional care relationship.

Conclusion: This study identified a wide range of attributes related to experienced quality of care from the perspectives of clients and formal and informal caregivers in home care.

Impact: Care providers are being challenged to structurally assess individual experienced quality of home care. This study underlines the importance of incorporating care preferences and experiences throughout the care process from a relationship-centred care approach. Relevant care measures and outcomes should be determined to gain insight and further improve individual care provision.

KEYWORDS
care relationship, experienced quality, home care, nursing, older people, quality of care, relationship-centred care

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1 | INTRODUCTION

Ageing in place is a common policy in Western societies to address rising costs and meet the needs of older people to remain in the familiar environment of the home (de São José, Barros, Samitca, & Teixeira, 2016; Wiles, Leibing, Guberman, Reeve, & Allen, 2012). Consequently, there is an increasing need for high-quality home care services and quality measures (Carpenter & Hirdes, 2013; O'Connor & Davitt, 2012; Wilberforce, Challis, Davies, Kelly, & Roberts, 2018). In the Netherlands, two types of formal home care services are provided in addition to domestic support: personal care and nursing care. Personal care and nursing care (referred to as 'home care') are both regulated by the Dutch healthcare insurance act (Zvw) and provided by teams comprising a district nurse, Registered Nurses (RNs) and nursing assistants/aides. This care is provided to community-dwelling older people who receive long-term care based on one or multiple chronic conditions and who are referred to in this article as 'clients'. The district nurse leads the care process by liaising with municipalities and coordinating the client's care, while RNs and nursing assistants/aides provide medical and personal care. Health insurers fund personal and nursing care in the Netherlands (Kroneman et al., 2016; Ministry of Health, Welfare, & Sport, 2018; OECD/EU, 2018).

In addition to formal care, informal caregivers play an increasingly important and active role in supporting care-dependent clients. Informal caregivers are unpaid family members, friends, or neighbours who provide assistance (Galiatsatos, Nelson, & Hale, 2017). They are seen as active care partners in providing home care in the Netherlands (Galiatsatos et al., 2017; Kroneman et al., 2016). Both formal and informal caregivers exert enormous effort in providing the necessary home care (Anker-Hansen, Skovdahl, McCormack, & Tønnessen, 2018). The Dutch national quality framework for home care recognizes these efforts, stating the need to use patient-reported experience measures to improve the primary care process and home care team functioning by understanding what clients and their family members experience as 'good care' (Stuurgroep Kwaliteitskader Wijkverpleging, 2018). Therefore, it is important to understand how quality of care (QoC) is individually experienced, thereby enabling clients and caregivers to reflect on their care experiences to improve care.

1.1 | Background

In defining experienced QoC, it is important to include the perspective of care receivers and providers in addition to frequently used normative quality indicators, such as safety, efficiency, or prevalence rates (Kroneman et al., 2016; Wolfe, 2001). Acknowledging the care receiver in the caregiving process, thereby understanding the needs and expectations of individual clients in home care, has attracted widespread support from both international institutions and organizations (Koksma & Kremer, 2019; Luxford, Safran, & Delbanco, 2011; Ritchie et al., 2018). However, existing patient-reported experience measures, such

as the Consumer Quality Index, do not capture the client's journey through the process, which is important for establishing the experienced QoC (Triemstra, Winters, Kool, & Wiegers, 2010). It was primarily developed to provide external accountability, public reporting and general quality improvements and it failed to address the needs of individual clients and caregivers to improve the primary care process (Voorhees et al., 2017). In addition to the clients' perspective, there is ongoing movement to include the experiences of both formal and informal caregivers in the caring process (Kogan, Wilber, & Mosqueda, 2016; McColl-Kennedy et al., 2017). Care provision and experiences with care depend on how we define ourselves and how we relate to others in a social network, as suggested by the relationship-centred care (RCC) approach (McCormack, Roberts, Meyer, Morgan, & Boscart, 2012; Soklaridis, Ravitz, Nevo, & Lieff, 2016). RCC places personhood and the importance of care relationships at its core, described as 'human interactions grounded in clinical caring processes' (Duffy & Hoskins, 2003, p. 82). Although the essence of home care provision can be viewed as meeting clients' needs, the dynamic relationship between clients and caregivers should be accounted for to understand the individual experiences with home care services (Fine, 2006; Tronto, 1993).

In a previous study on conceptualizing quality in long-term care the INDividually EXperienced QUAlity of Long-term care (INDEXQUAL) framework was developed, describing the care process and general concepts related to the experienced quality of long-term care (both home and nursing home care) from a RCC perspective (Sion et al., 2019) (Figure 1). The framework was developed based on an iterative literature review of existing frameworks and consultation with stakeholders from different long-term care settings. The development of INDEXQUAL was informed by frameworks such as the Senses Framework, SERVQUAL, and the Quality-Caring Model (Duffy & Hoskins, 2003; Nolan, Brown, Davies, Nolan, & Keady, 2006; Parasuraman, Zeithaml, & Berry, 1988). For instance, the Senses Framework's six senses (security, continuity, belonging, significance, purpose and achievement) are seen as the basis of personal needs, shaping individual care experiences from RCC (Nolan, Davies, Brown, Keady, & Nolan, 2004). By integrating insights from this and other frameworks, the importance of care relationships throughout the care process for experienced QoC was emphasized. INDEXQUAL describes experienced quality in terms of expectations before care is provided, experiences during the actual care provision taking place in care relationships and an evaluation of this experience afterwards. Each individual is unique in terms of personal characteristics, influencing their quality experience with the caring context (Chow, Mayer, Darzi, & Athanasiou, 2009; Sandager, Freil, & Knudsen, 2016). Clients and formal and informal caregivers can hold converging or diverging views about key features of home care provision, such as determining when care needs are met (Han, Kim, Storfjell, & Kim, 2013). It is therefore expected that both clients and caregivers in the home care environment have unique representations of the care process. However, it is unknown what these representations
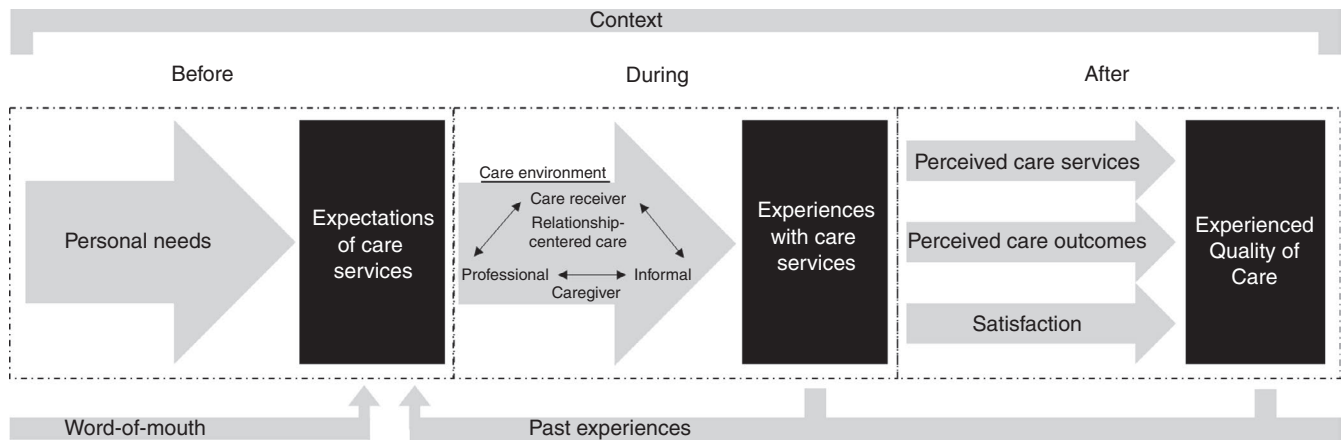
FIGURE 1 INDEXQUAL—conceptual framework of experienced quality of long-term care (Sion et al., 2019, p. 2)

from different perspectives entail relating to the experienced quality in home care.

Although the INDEXQUAL framework describes the care process related to experienced QoC services in general, it requires further operationalization for the home care setting when measuring experienced QoC. Thus, evaluating experienced QoC is dependent on the process of care, its context and the perspectives of the people who are involved (Koksma & Kremer, 2019). It is therefore essential to investigate the attributes determining experienced quality from the perspective of the client and from formal and informal caregivers. This is necessary to operationalize, evaluate, and ultimately improve the experienced QoC in home care.

2 | THE STUDY

2.1 | Aim

This study sought to explore and understand the views of clients and formal and informal caregivers about the experienced quality of home care for older people.

2.2 | Design

A descriptive, qualitative study was conducted using individual, semi-structured interviews with clients, their informal and formal caregivers. Insight from a pre-study into existing experienced quality frameworks and the INDEXQUAL provided guidance for data collection and analyses (Sion et al., 2019).

2.3 | Setting and sample

The research took place in two publicly funded, team-based home care organizations of the Living Lab in Ageing and Long-Term Care South Limburg (Verbeek, Zwakhalen, Schols, & Hamers, 2013). Three perspectives in existing home care triads were included in this study, consisting of one client, one informal caregiver and one home care nurse/assistant. Purposive sampling was executed based on the client's experienced care relationship perceived by

the formal caregiver, where a balance was strived for regarding less complex versus more complex relationships or situations, presence of an informal caregiver (spouse or other) and the client's residence (living in the community or sheltered housing estate). All informal and formal caregivers were eligible if they currently worked in Dutch home care as a district nurse, RN, or nursing assistant and were recruited to vary in function. Participants were recruited via the district nurses from the participating organizations. Home care clients living at home and their direct (most active/involved) formal caregiver were identified and contacted by the district nurse. Participating clients were (in the district nurses' opinion) both mentally and physically able and received care from both informal and formal caregivers. District nurses first consulted their clients, formal, and informal caregivers before providing contact information. Those willing to be approached received a letter informing them of the purpose of the study. They were contacted by telephone by the research team and asked to participate in a face-to-face interview. Participants were recruited until data saturation was reached.

2.4 | Data collection

Individual semi-structured interviews were scheduled at a location preferred by the participant. The interviews were preferably conducted separately with participants. If necessary, the informal caregiver could support the client in the interview but was asked to not actively engage in the conversation (e.g. in case a client had trouble speaking clearly). The planned duration of the interviews was 1 hour. A topic list, guided by the INDEXQUAL framework for the client and formal and informal caregiver, was used (Table 1). The researcher took notes during the interviews, later fleshed out these notes with details and used them as data along with the interviews.

For participants needing help in elaborating on some of the abstract topics (three clients, one informal and three formal caregivers), questions were facilitated using photo elicitation during the interviews (Dewar, 2012). Using photos in combination with asking questions may elicit information in a different manner than using words alone (Harper, 2002). A collection of generic photos (e.g. people,

TABLE 1 A priori themes and operational definitions, based on the INDEXQUAL framework

Theme	Operational definition
Personal needs	Individual needs related to home care services
Word-of-mouth	Personal and non-personal statements made by parties other than care organization or care receiver, conveying expectations of home care services
Past experiences	Emotional judgements on previous care experiences beyond the home care services
Expectations of care services	Desired and/or adequate expectations of home care service quality
Relationship-centred care attributes	Interpersonal attributes of relationships influencing both expected and experienced care quality
Experiences with care services	Emotional judgement about the sum of all care interactions related to home care services
Context	Care receiver characteristics and the setting in which care is delivered

animals, objects, landscapes and scenery) from the MyHomeLife visual inquiry tool was used (University of the West of Scotland, 2017). Participants selected a photo best representing their feelings about a certain topic (e.g. for the relationship with the caregiver) and were asked to explain their choice. Afterwards, participants were asked to fill in several demographics.

2.5 | Ethical considerations

The study protocol was approved by the medical ethics committee (METCZ20180003), which concluded that the study did not fall under the scope of the Medical Research Involving Human Subjects Act. Participants were informed about the aim and expected burden of the study verbally and in writing and gave their written informed consent to voluntarily participate and have the conversation audiotaped.

2.6 | Data analysis

All interviews were audiotaped and transcribed verbatim. Field notes were taken by the interviewer to log the context of the interviews and provide meaning to the reported experiences. Paraphrasing was used during and after individual interviews to determine accuracy and correct interpretation with the participant. All interviews were analysed by means of directed content analysis (Hsieh & Shannon, 2005) using MAXQDA Standard 2018. The themes of INDEXQUAL were used as a priori coding themes (Table 1). Using condensation, each previously coded meaning unit was shortened while preserving the core meaning (Graneheim & Lundman, 2004). Next, the condensed text was interpreted using a higher logical level, also known as abstraction. This was followed by sorting, labelling, and

categorizing the abstracted text, for which categories and subcategories were constructed deductively. Two researchers (RH & TTL) individually coded six transcripts (first and fourth triad) to assess and increase confirmability between researchers. A third independent rater (SZ) assessed the coding process by random sampling. Throughout the analysis, both researchers (RH & TTL) reflected on the data and discussed the discovery of possible new (sub)categories. All research steps and argumentation processes were logged and reported in a detailed codebook throughout the data analysis. Afterwards, all participants were invited for a group meeting. During this meeting, participants received a presentation of the findings and were asked to reflect on any omissions.

2.7 | Rigour

Several strategies recommended by Korstjens and Moser (2018) were used to meet the criteria of credibility, transferability, dependability, confirmability, and reflexivity, thereby strengthening the trustworthiness of this study (Lincoln & Guba, 1985). To increase credibility, the results were presented during two group meetings with nine participants to verify correct interpretation and completeness of the results. To enhance transferability, a detailed description was made on the context of the research, setting, sample, demographics, and exemplary quotes. Furthermore, a detailed codebook was made to keep track of all theory-driven (themes) and data-driven codes (categories and subcategories) during the analysis.

3 | FINDINGS

3.1 | Participants

Between April 2018 - November 2018, a total of 18 semi-structured interviews with 16 participants were conducted and lasted 54 min on average. One formal caregiver (district nurse) participated in three different care triads as the formal caregiver. Interviews took place in six existing home care triads, each consisting of a client and an informal and formal caregiver. Table 2 provides information about the context of each triad and demographics of the participants.

3.2 | Identified categories per experienced quality theme

An overview of the findings based on the a priori themes is listed in Table 3. Next, we will discuss the discovered attributes (both categories and subcategories) following the order of the individual themes of the INDEXQUAL framework. Following that, the findings per theme are presented by combining the perspectives of the client and the informal and formal caregiver.

3.2.1 | Personal needs

Based on the responses of participants relating to the *type of personal needs*, most participants mentioned current *care needs* for

TABLE 2 Demographics of individual triads (N = 16)

Triad	Care needs	Client	Informal caregiver	Formal caregiver
1	Activities of daily living (ADL) support (personal hygiene, compression stockings, eye drops) ostomy care, medication assistance, wound treatment	M, 77 years, married, 7 hr home care (since 5.5 years), 4.3 hr. domestic,	F, 77 years, wife, lwc, 30 hr inf. care	F, 25 years, district nurse, 36 hr contract, 3 years exp
2	ADL support (personal hygiene, meal preparation)	F, 96 years, widow, 3.5 hr home care (since 5 years), 3.3 hr. domestic	F, 67 years, daughter, not lwc, 46 hr Inf. care	F, 25 years, district nurse, 36 hr contract, 3 years exp
3	ADL support (personal hygiene, dressing), medication assistance	F, 84 years, married, 3.5 hr home care (since 3 years), 4 hr domestic	M, 83 years, husband, lwc, 42 hr Inf. care	F, 25 years, district nurse, 36 hr contract, 3 years exp
4	ADL support (personal hygiene, compression stockings, meal preparation), medication assistance	F, 86 years, married, 7 hr home care (since 1.5 years), 2.8 hr domestic	M, 86 years, husband, lwc, 24 hr Inf. care	F, 31 years, nursing assistant, 24 hr contract, 4 years exp
5	ADL support (personal hygiene)	M, 86 years, married, 7 hr home care (since 1.5 years), 2 hr domestic	F, 67 years, wife, lwc, 67.2 hr Inf. care, pjob	F, 63 years, RN, 24 hr contract, 15 years exp
6	ADL support (personal hygiene, compression stockings, eye drops)	F, 85 years, married, 3 hr home care (since 5.5 years), 2.5 hr. domestic	M, 59 years, cousin, lwc, 4 hr Inf. care	F, 61 years, nursing assistant, 30 hr contract, 30 years exp

Abbreviations: M = male, F = female, domestic = hours domestic help per week, home care = hours home care per week, (not) lwc = (not) living with client, Inf. care = hours informal care per week, pjob = paid job, exp = years of experience working in home care.

which home care was needed (e.g. help with personal hygiene). In addition, some also mentioned *emotional needs* (e.g. dealing with grief) and *social needs* (e.g. need for a conversation).

With respect to *dealing with personal needs,* participants often mentioned ways they *communicated about personal needs* (e.g. discovery of personal needs by formal caregivers). Also discussed were the topics of describing the care process and activities to *fulfil the client's needs.* Formal caregivers mostly focused on how to *discover (hidden) personal needs* of their clients. In some instances, the formal caregiver was aware of a client's unfulfilled personal need. The type of care need was, however, seen as *conflicting with professional care standards* and thus, falling outside that person's role as professional caregiver (e.g. clipping of nails). In two cases, care needs were determined based on professional standards (e.g. what would be best for the client), as opposed to accepting the personal client's needs (e.g. what does the client want).

3.2.2 | Word-of-mouth

Regarding word-of-mouth information, some clients *compared their care provision with others,* for instance based on information received from relatives and neighbours. Participants mentioned this when the care was seen as out of line compared with the word-of-mouth information. For instance, one client heard that her friend receives home care from two formal caregivers and was therefore dissatisfied with the large number of different formal caregivers from whom she receives care:

> [I would like] a more fixed team of formal caregivers.
> . . . My friend in Maastricht, she has the same formal
> caregivers. Only those two.   (client 6)

3.2.3 | Past experiences

Past experiences with former home care services were described by both clients and informal caregivers. This was mostly a result of moving to a different house and changing the home care organization. Although the quality of medical care was often seen as similar between different services, a comparison was made between previous and current formal caregivers. From a caregiver's perspective, one nursing assistant mentioned that her past experience working in a different team resulted in trying to motivate her client to become more self-reliant:

> I already came from another team, well they valued
> self-management highly. So, if you can wash yourself .
> . . then we will not do it.   (formal caregiver 1)

Past experiences in an institutionalized care setting (e.g. hospital admission) in some cases led to a comparison between formal caregivers in the two different care settings. One client was very dissatisfied about care received during hospital intake, especially when he compared the formal caregivers in the two settings:

TABLE 3 Categories and subcategories based on the a priori main themes

Themes	Categories	Subcategories
Personal needs	Type of personal need	*Care needs, social needs, emotional needs*
	Dealing with personal needs	*Communicating needs, fulfilling needs, professional standard conflicting with needs*
Word-of-mouth	Compare care provision with others	
Past experience	Past experience former care services at home (e.g. other home care team, organization, or domestic care)	
	Past experience institutionalized care services (e.g. hospital admission)	
Expectations of care service	Based on previous experience current home care services	
	Based on familiarity formal caregiver	
	Based on available information and communication	
Relationship-centred care	Type of care relationship	*Personal care and/or professional care relationship*
	Aspects of care relationships	*Knowing and understanding the other, opening up to the other, thinking along with the other, trusting the other, motivating the other*
	Balance between care relationships	*Polarization/form subgroup, equality*
Experiences with care services	Aspects influencing the care experience	*Small regular care team, perceived availability of time, following up care appointments, personal factors*
	Integrating care with daily life	*Discovering (former) way of living, care routines, fit care planning with way of life*
	Working together with each other	*Sharing common goal*
	Open communication	*Humour, addressing sensitive topics*
Context	Organizational and occupational aspects	*Role conflict, working conditions*

> I receive very warm-hearted (home) care, warm-hearted care and that actually differs completely compared to the general hospital, it differs completely! They [in the hospital] are not sensitive, they are more business-like.
>
> (client 5)

3.2.4 | Expectations of care service

With regards to expectations in home care, most expected a continuity of care *based on previous care experiences* with current home care services. However, both clients and informal caregivers mentioned that knowing which *familiar formal caregiver* to expect helped to create more realistic expectations about the care. For instance, one informal caregiver clearly indicated that her mother does not like to be showered and only one specific caregiver would succeed in this task:

> If you say [specific caregiver] is coming in the morning, then you already almost certainly know she will get her into the shower. Because my mother never really wants to be showered.   (informal caregiver 6)

The *availability of information* obtained from patient files or speaking with colleagues about the client helped the formal caregivers to create a clear picture of both the clients' care expectations and their own expectations as caregivers. Some formal caregivers, however, preferred to provide care with as little pre-obtained information, other that medical information, of the client as possible:

> If you're blank [no information beforehand], of course you look with a much broader view . . . except for the medical aspects, those things I would indeed like to know.   (formal caregiver 6)

3.2.5 | Relationship-centred care attributes

Care relationships were seen as important in home care and two *types of care relationships* can be distinguished based on the responses: a *professional* and a *personal care relationship*. A professional care relationship was often seen as being the result of providing appropriate medical care. On the other hand, a personal care relationship (e.g. having a 'connection') was strived for by most. Participants noted *aspects of care relationships* as *knowing and understanding* others in the home care environment. *Opening up and thinking along* with others, in addition *to trusting and motivating* each other during care provision, were seen as important aspects for personal care relationships. Some formal caregivers indicated that a more complicated medical

condition made it easier to build a personal care relationship with their client. One formal caregiver reflected on how 'being liked' by others helped her to form personal care relationships and be trusted:

> If people like you, they are more inclined to trust you. With others . . . you will really need to prove that you are capable of things. And if you are only there to administer eye drops . . . then of course you cannot prove yourself. (formal caregiver 6)

In addition, discovering similarities with clients (e.g. hobby) or just the amount of time spent together were also seen as fundamental in building a personal care relationship:

> If you do have a 'connection' with people or a similar background, it is of course easier to build a relationship than when you don't. (formal caregiver 6)

Informal caregivers regarded care provision as something that is naturally done for a spouse or relative and as gradually increasing when a relative is in need of more (intense) care. Clients focused mostly on reasons why they did or did not prefer specific caregivers. However, some clients pointed out that they do not look for a 'connection' with their formal caregiver at all and prefer to have a more professional care relationship. Often, a more pleasant formal caregiver was linked to having the right personal 'characteristics', providing 'warm cooperative care' or just being 'nice'. The picture of holding hands and embracing people was often used by participants to describe their feeling of a care relationship with their formal caregiver, as the following quote shows

> The card with the two holding hands. . . . Yes, this already illustrates it. The warmth, it is probably a child's hand holding an adult, but the fact that it goes hand-in-hand. Yes, that is how it feels, hand-in-hand. (client 5)

In terms of the *balance between care relationships*, clients and their spousal informal caregivers in our sample expressed feelings of a strong unity. This sometimes led to *forming a subgroup* within the care context, thereby increasing the personal distance with the formal caregiver. This was especially the case when clients and informal caregivers indicated a large number of differing formal caregivers, without a clear preference for one specific caregiver. However, in one occurrence, the spousal informal caregiver expressed a strong connection with the formal caregiver. In this case, the informal caregiver mentioned that her husband tried to polarize against the formal caregiver, to undermine the authority of the formal caregiver.

3.2.6 | Experiences with care services

With regard to how care is experienced, some *aspects influencing care experiences* were important for participants to have a positive outcome. Most of the clients and informal caregivers valued a *small*

number of formal caregivers, despite recognizing that this might not always be possible. Some clients and informal caregivers (mostly spouses) communicated a clear preference for certain *personal factors* related to positive care experiences (e.g. do not like to be showered by a male caregiver) and they stressed the importance of the right care being provided at the right time. Although formal caregivers indicated that the *availability of time* per client is limited, they stressed that clients should not experience time pressure:

> It's the most pleasant if you always get the same caregivers, but that does not happen. It changes quite often. (client 5)

Integrating care with daily life by *discovering the former way of living* before care was needed was mentioned by several formal caregivers. This varied from applying make-up to finding participants to talk about and adjusting *care planning to fit care with personal life*. These 'discovered extras' were personally valued from all perspectives and important in *care routines* fitting with clients' previous and current ways of living:

> I think it's very important to pay attention to the period in their lives where they lived independently. What did you do back then? Did you apply make-up or not? (formal caregiver 5)

Clients and formal and informal caregivers considered *working together with each other*, thereby *sharing a common goal* in the care process, as vital in establishing proper care. Some formal caregivers found it important that the type of care should be tailored to the client's experiences, thereby potentially ignoring their own experiences as a caregiver. However, some formal caregivers struggled in coping with negative experiences of a client as a result of their professional care (e.g. first-time provision of incontinence pants). Others, however, had to provide care using medical aides (compression garments) because of their own medical condition as a caregiver. In two cases, this had resulted in conflicts and resistance to care by the client. One client elaborated on an occasion when she was initially not pleased about the introduction of a new care aide, although now being satisfied about the outcome and knowing the reason why this care aide was needed:

> Of course they have quarrelled a lot with me about putting on the stockings . . . but now I think it's ok. And also for the girl [formal caregiver], she had a hand condition. (client 1)

Finally, establishing *open communication* was seen as important for the care experience. Formal caregivers indicated that they strived for a caring environment where both clients and informal caregivers openly communicate and reflect on care experiences. Informal caregivers and clients, despite being aware of the limited time available, shared this view. Furthermore, *humour* was seen as important from all

perspectives to create a more relaxing atmosphere. This was especially true when specific care tasks were seen as potentially discomforting for the client. Different ways to *address sensitive topics* during care provision (e.g. loss of a partner) were discussed and were seen as important for the QoC.

3.2.7 | Context

The context of the participants involved information about *team, organizational and occupational aspects*. Most formal caregivers described their *role and how it conflicted* with performing certain informal and care tasks. One example noted especially was the inability to drink a cup of coffee with a client or perform specific medical tasks without consulting a GP first. Some perceived this as influencing their autonomy as formal caregivers:

> [Relating to a specific medical procedure] yes, we did that before, we just did that! And now that is not allowed. . . . While you do it on your own professional insight and competence. Hey, I know how it should be done, because it was taught to me a long time ago. And now you must ask a physician for permission.
>
> (formal caregiver 2)

Discontent about *working conditions* such as the terms of employment of formal caregivers was mentioned by all perspectives. A shortage of staff in their team was mentioned by some formal caregivers and was related to feelings of work pressure, a lack of energy and the effect it might have on the QoC provided. Some informal caregivers were also aware of these working conditions in the care organization. They indicated that they were understanding towards individual formal caregivers and the negative consequences for their lives and the life of the client (e.g. scheduling issues). Relating to the work atmosphere in the organization or team, some mentioned that there currently is no structure or safe environment to discuss or evaluate individual care situations:

> I am full of admiration, also for the pressure they have at the moment with actually far too few staff. . . . I do worry for them because I'm afraid they cannot cope with the pressure at a given moment.
>
> (informal caregiver 2)

4 | DISCUSSION

This study showed a variety of attributes throughout the caregiving process. Before care was provided, some personal needs conflicted with professional care standards and thus, fell outside the caregiver's professional standards. Anticipating a familiar formal caregiver helped clients form realistic expectations of fulfilling these needs. During care provision, care routines fitting with the care receiver's former way of living were seen as important contributors to experienced

QoC in home care. For the relationship between client and formal caregiver, a more 'close' personal care relationship was preferred over a more 'detached' professional care relationship. Other attributes that were seen as beneficial for positive care experiences were a small number of caregivers, perceived sufficient time for care provision and a caring atmosphere facilitating open communication and humour. Aspects on an organizational, team, or occupational level such as staff shortages and work pressure influenced QoC from a contextual level in home care.

This study contributes to understanding the individual attributes shaping the experienced QoC from multiple perspectives and underlines the importance of simultaneously applying aspects of both individualized and RCC in providing home care. Although most attributes were described by at least two perspectives (Table 2), some attributes were not mentioned by the other perspectives as related to experienced quality. These differences in perspectives show that obtaining insight into the perspective of the other and sharing one's own perspective in home care are of great importance for providing the desired care and determining the experienced QoC. Therefore, a true understanding of the experiences, concerns and viewpoints from the participating perspectives should be strived for, and the ability to communicate these insights (Hojat et al., 2002). To truly understand the perspective of the other, putting one's own mental frame, beliefs, assumptions, knowledge and experience temporarily on hold may be necessary (Goossensen, 2014). This notion is supported by RCC, where all relationships between the perspectives are considered and are deemed necessary to provide high QoC (Duffy & Hoskins, 2003; McCormack et al., 2012; Pew-Fetzer Task Force & Tresolini, 1994). Care relationships, based on trust between people of old age and general nursing staff, are a key element in determining QoC (Fosbmder, 1994). Our results show that feelings of trust and opening up to each other were seen as important attributes in personal care relationships and QoC in home care from all perspectives. This is also recognized by the new Dutch quality framework for home care, stating that formal home care is inextricably linked to building trustful and equal care relationships (Stuurgroep Kwaliteitskader Wijkverpleging, 2018).

This study and others demonstrate that experienced QoC is a great deal more than meeting perceived care outcomes and more focus is needed to gain insight into attributes of experienced QoC and the relationships in the care environment (Bjerregaard, Haslam, Mewse, & Morton, 2017; Lyons, Zarit, Sayer, & Whitlatch, 2002). To obtain the most valid view of QoC, the importance of implementing self-reported measures from several perspectives in the home care environment should be acknowledged (Curyto, Van Haitsma, & Vriesman, 2008). The INDEXQUAL framework proved a robust guide in our quest to chart the care process where no additional data emerged that could not be mapped onto the initial themes. It, however, was not developed to operationalize experienced quality for a specific long-term care setting. In this study, we aimed, as a first step, towards investigating relevant attributes of experienced QoC in home care. Further work should go towards understanding the needs and requirements for developing a measurement for experienced QoC in this setting.

4.1 | Limitations

Several limitations require consideration. First, participants were asked about experiences and attributes with the caring process at one point in time. Consequently, a possible recall bias is present that could have resulted in a misclassification of care expectations, previous care interactions and possible outcomes by the participants. To control for this, participants were encouraged to provide concrete examples of care interactions during the interviews. Second, one district nurse participated in three care triads, which could have resulted in over-representation of her perspective. During the analyses, this was taken into consideration by combining and mitigating the results of all caregivers before interpreting the findings. Third, the interviewers and interviewees did not have an existing relationship prior to the interviews. This might have inhibited participants from talking openly. Participants were therefore interviewed in the environment of their preference, efforts were made to make participants feel at ease beforehand and some interviews were held in dialect when preferred. Fourth, the components of the framework used in this study were used both as general topics in the interview guide and coding themes in analysing the findings. To account for possible confirmation bias, participants were encouraged to elaborate on other relevant topics related to their experienced care quality beyond the interview guide questions, for example by using photo elicitation.

5 | CONCLUSION

Older people living at home receive more prolonged home care as a result of ageing in place policies; thus, more attention should go to long-term care relationships between clients and (in)formal caregivers. Since receiving care is generally regarded as a discontinuity of one's past life, our results show that care routines should fit with the client's former way of living to improve the experienced QoC. Care relationships based on trust and openness to each other should be strived for in general, while providing space to account for individual differences. Clients and caregivers should be aware of the perspective of the other when evaluating care experiences. Attention should be paid to gaining insight into individual preferences relating to the home care process. The findings have implications for how to operationalize experienced QoC by a variety of care attributes from multiple perspectives. The attributes found in this study can help home care organizations and professionals in understanding experienced quality from a RCC approach. However, more research is needed to develop instruments to structurally assess experienced QoC in home care. It is furthermore a necessity to determine which attributes are most relevant for each care context to account for individual preferences.

CONFLICT OF INTEREST

The authors declare that they have no competing interests.

AUTHORS' CONTRIBUTIONS

RH conducted the interviews, analysed, and interpreted the results and wrote the manuscript. TTL co-conducted interviews and was second coder during analyses. SZ was involved as third independent rater in the coding process. TTL, SZ, and SB were involved in the design of the study and critically revised the manuscript for important intellectual content. All authors read and approved the final manuscript and agree accountability for all aspects of the work, ensuring investigating and resolving questions related to the accuracy or integrity of any part of the work.

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