HUMAN RIGHTS IN DUTCH GERIATRIC CARE

A qualitative research on the experiences of elderly in receiving geriatric care in relation to their human rights

By Joceline Kranenburg

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A qualitative research on the experiences of elderly in receiving geriatric care in relation to right to health

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Summary

A qualitative research on "Human rights in Geriatric care" was conducted under the supervision of the Johannes Wier Foundation and the Athena Institute. The research objective was to gain insight in experiences and opinions of elderly clients who use of long-term geriatric care, with respect to their human rights.

In the past decades the Dutch population has a growing number of elderly. Because of this, the increase in demand of geriatric care is a serious challenge. The government demands a better efficiency in this sector of healthcare, while there is not enough personnel. Budget cuts are made, while various researches show that quality of care is affected by this. In relation to human rights and the "right to health", the Committee on Economic, Social and Cultural Rights expressed their concerns on reports that elderly are denied appropriate care in the Netherlands. This is due to a lack of trained staff, the insufficient number of care takers and the absence of a comprehensive enactment on geriatric healthcare. Therefore, the essential elements of "right to health" should be improved and monitored extensively. Even though, some of the elements of the "right to health" are monitored by using the IQ-index within the institutions where geriatric is provided, not enough aspects of the "right to health" and general human rights are taken into account.
None of the past researches done in the field of quality of healthcare reflect the opinion on human rights aspects of the elderly client in long-term geriatric care. For this reason it was of importance to do a research on this topic. Therefore the following research question was posed in order to meet this objective: *"What are experiences and opinions of elderly clients on received care (in the form of institutional care) in relation with human rights principles?"*

Fourteen personal semi-structured interviews were conducted with elderly people within three institutions throughout the country. At each of these institutions also a focus group interview was conducted for triangulation purposes. The main topics of these interviews and the focus group interviews were: the "right to health" principles: *Accessibility, Acceptability, Availability* and *Quality* and the human rights principles: *Dignity, Autonomy, Equality, Fairness and Respect.* The interviews were analyzed and compared to recent research on quality of geriatric care.
From the analyzed data, it can be concluded that the main issues in long-term geriatric care in relation to human rights principles are the following: 1) elderly know little about their rights and what the "right to the highest attainable health" entails and there is a lack of (good communication of) information on this; 2) the availability and quality of health care staff. Quality of care in this research was dependent on the individual providing the care and on the level of training of the healthcare staff. 3) Within the concept of dignity, results show that dependency and personal attention affected the respondents' feeling of dignity. 4) Autonomy is an important concept for elderly; however they give part of their autonomy away.

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Contents

List of abbreviations

Centraal bureau of Statistics - CBS

Centraal Indicatiestelling Zorg – CIZ

International Covenant on Economic, Social and Cultural Rights -ICESCR

Consumer Quality Index – CQ-index

Equality and Human Rights Commission - EHRC

National Institute for Health and Environment – RIVM

Netherlands Institute for Health Services Research - Nivel

Organization for Economic Cooperation and Development - OECD

Universal Declaration of Human Rights -UDHR

Human Rights Education -HRE

World Health Organisation – WHO

Zorgzwaartepakket/care level package – ZZP

Chapter 1: Background

This part will address an introduction on this research. The background description is a result of a literature study and gives an image on the context of this research.

In the past decennium the demographic of Dutch population aged rapidly. In 2009 there were over 2,5 million people above the age of 65. The National Institute for Public Health and Environment (RIVM) estimates that in 2050 there will be about 4,5 million elderly, which will be about a quarter of the Dutch population (Zantinge, Wilk, Wieren, & Schoemaker, 2011). In 2008, about one third of elderly persons experienced one or more disabilities and 1 out of 5 elderly persons suffered from a chronic disease (Uijen & Lisdonk, 2008) (Gool, Picavet, Deeg, Klerk, Nusselder, & Boxtel, 2011). For these disabilities and diseases, about 20% of elderly persons in the Netherlands received home care, which varied from domestic help to technical medical practices (Zantinge, Wilk, Wieren, & Schoemaker, 2011) (Centraal Bureau voor de Statistiek (CBS), 2010).

Older people experience more disabilities and chronic illnesses, which call for different types of healthcare. In the Netherlands there are several possibilities of treatment in geriatric care; primary, secondary, long-term healthcare, or a combination of these.

§1.1 Healthcare in the Netherlands

Primary healthcare is seen as the essential healthcare, using evidence based practice. Primary healthcare is the first contact for clients. Examples of primary healthcare professionals are: General practitioners, physical therapists, pharmacists and midwives (General Assembly of the United Nations, 2011).
Secondary healthcare are services provided by medical specialists and other health professionals who get a referral from the General practitioner. Examples of professionals in these services are cardiologists, orthopaedic surgeons and urologists (General Assembly of the United Nations, 2011).
Long-term healthcare includes variety of medical and non-medical services, over an extended period of time, which addresses the needs of people with a disability who can no longer care for themselves. The organization for economic cooperation and development (OECD) defines long-term healthcare as "A *range of services for people who depend on on-going help with activities of daily living caused by chronic conditions of physical or mental disability'* (General Assembly of the United Nations, 2011).

The focus of this research was on long-term healthcare. For elderly in the Netherlands this is available in two forms: home care and institutional care (nursing homes). In home care, medical services are provided in that person's home. The aim is to stimulate and support the client in their home environment in activities they are not capable performing themselves (Arcares, 2005). In institutional care, the aim is to achieve an environment to which it is liveable for the person, even though they suffer from severe diseases and disabilities. Therefore, the client is stimulated in what they are still capable of doing independently and provide support in the things they can no longer do (Leistra, Liefhebber, Geomini, & Hens, 1999). Responsibilities of the healthcare professionals (these consist of specialized doctors, nurses, paramedics and housekeeping) in home care and institutional care include supporting the client in basic personal care (hygiene), support in their household, fulfil technical nursing practices like wound care, provision of information, advice, instruction and assist the client with psychosocial issues (Haterd, Liefhebber, Luijkx, Mast, & Dam, 2005) (ActiZ, 2012).

§1.2 Current challenges in geriatric care

With increasing numbers of elderly in Dutch population also comes a higher demand for geriatric care. In the period of 1999-2007 healthcare expenses increased with an average yearly rate of 6,8%. On a yearly basis, geriatric institutional care expenses entail almost 10 billion euro. Demand in care is expected to increase with an average of 3,4% yearly till 2030, which will have healthcare expenses rise. While expenses and demand are expected to rise, the labour market in this sector is expected to decrease. (Centraal Bureau voor de Statistiek (CBS), Gezondheid en zorg in cijfers 2009, 2009) (Zantinge, Wilk, Wieren, & Schoemaker, 2011) (Centraal Bureau voor de Statistiek (CBS), Statline, Centraal bureau voor Statistiek, 2012) (Centraal Indicatiestelling Zorg (CIZ), 2012).

With the demand of healthcare growing and the decrease in the labour market, efficiency is of major importance for upcoming years. Last years, health professionals in geriatric care experienced an increasing workload, due to an increase in demand for care on one hand and an understaffing on the other hand. Also an increase of administrative tasks pressures the workload of health professionals. ActiZ, which is an organisation of entrepreneurs in the nursing homes and home care and promotes the common interests of its members, annually, performs a benchmark report which evaluates given geriatric care. In the report of 2011, one of the healthcare professionals who conducted a questionnaire mentioned *"I work with much pleasure, but the workload is getting higher and higher, and the administration is getting out of hand. I want to work on the bedside and not in an office*". This gives an impression on how health professionals generally feel about the workload geriatric healthcare (ActiZ, 2011).

The government promised that in upcoming years extra money will be invested to attract more staff in geriatric care. The Netherlands Institute for Health Services Research (Stichting Nivel) expresses that it is important to not only have an emphasis on quantity, but also invest in quality of care. One of the challenges is to adapt education to the complexity in care for elderly (Stichting Nivel, 2012).

§1.3 Problems experienced by elderly clients living in institutions

Not only health professionals think there is an understaffing of employees. In this report it was also stated that based on the CQ-index (Consumer Quality Index), which measures the customer satisfaction from a clients' perspective, more focus should be put on availability of staff. Clients experience a shortage in availability in healthcare staff to give good quality care. For home care clients, this is even their most prominent complaint (ActiZ, 2011).
Other problems clients in geriatric care experience are that they are very dependent on received care and lack of information and participation in deliberation and decision making processes. Therefore, it is a challenge in the upcoming years to insure the autonomy of the elderly client (ActiZ, 2011) (Stichting Nivel, 2012). Because elderly clients are so dependent on healthcare services, and thus in a vulnerable position, the risk of violation of human rights or "right to health" is higher. Therefore, it is important to explore what is the current status the human rights and "right to health" of the elderly client.

§1.4 Human rights

Human rights are defined in the Universal Declaration of Human Rights (UDHR) and apply to everyone, whatever nationality, age, place of residence, skin tone, religion, language or status (United Nation (UN), 2012). Elderly clients who are living in nursing homes and thus receiving institutional healthcare services "the right to health" is of major importance. The "right to health" is described in different international treaties and can be defined as "*the right of enjoyment of everyone to the highest attainable standard of physical and mental health*" or as "*the right to a standard of living adequate for the health and well-being of himself and of his family*" (United Nations (UN), 1948) (United Nations (UN), 1996). To attain the highest attainable standard of physical and mental health, the state must provide health facilities, services and goods to achieve this for every person in society.

This right is interdependent and closely related to other human rights like right to housing, human dignity, non-discrimination, equality, prohibition against torture and privacy. Therefore, violation of "right to

health" may impair the enjoyment of other human rights and vice versa (Comittee on Economic, Social and Cultural Rights, 2000).

§1.5 Human rights in geriatric care

Human rights apply to everyone, but they are particularly significant for vulnerable groups of people who have a greater risk of poor treatment. Elderly clients, as described previously, who make use of long-term geriatric care, are at a higher risk of violation of their human rights (Equality and Human Rights Commision (EHRC), 2011). Several researches have been done on the quality of healthcare; still few of these entail the clients' perspective on the violation of their human rights principles and "right to health" principles(ActiZ, 2011)(Nivel, 2012).

The Economic and Social Council of the United Nations assessed the compliance of the covenant of Economic, Social and Cultural Rights (ESCR) in 2010 for the Netherlands. In the concluding observations concerns were expressed that many elderly clients are denied appropriate care in the Netherlands, including in nursing homes. The cause of this problem is due to lack of trained staff, the insufficient number of care takers and the absence of a comprehensive enactment on geriatric healthcare. Priority of the state in this respect should be to improve the geriatric healthcare system to ensure the "right to health" principles: availability, accessibility, acceptability and quality of care. Therefore, a strategy should be made on the health of elderly. For this, quality of geriatric facilities, goods and services should be monitored thoroughly and an effective inspection mechanisms should be adopted (Committee on Economic, Social and Cultural Rights, 2010).

In response to these concluding observations, the Johannes Wier foundation would like to gain more insight into the relationship between human rights and geriatric care and to take into consideration the perceptions of the elderly clients. Therefore, this research focusses on the experiences of elderly clients making use of long-term geriatric healthcare in the form of institutional care with respect to human rights principles.

§1.6 Johannes Wier Foundation

Johannes Wier Foundation is a non-profit organisation which was founded by healthcare professionals in 1986. Activities of the foundation include providing information and education on human rights (especially "right to health") for doctors, nurses and other healthcare professionals. They provide education and information, the organisation organises debates and meetings to discuss dilemmas on difficulties in, for example, care for illegal immigrants, elderly, and medical secrecy (Johannes Wier Stichting, 2012). The Johannes Wier Foundation is the commissioner for this research project.

§1.7 Problem field leading to the research question

Due to ageing of the population and better treatment methods, there is a growing number of elderly in the Netherlands. With this growing number of ageing people, the pressure on current healthcare systems is increasing. The increase in demand of geriatric care is a serious challenge. However, the government demands a better efficiency in this sector of healthcare, while there is not enough personnel. Various research results show that the quality of care is affected by this (ActiZ, 2011) (Stichting Nivel, 2012).
Quality of care is inherently connected with human rights principles. With respect to these human rights principles, concerns were expressed that many elderly are denied appropriate care in the Netherlands. The cause of this problem is a lack of trained staff, the insufficient number of care takers and the absence of a comprehensive enactment on geriatric healthcare (Committee on Economic, Social and Cultural Rights, 2010). Therefore, the essential elements of "right to health" should be improved and monitored extensively.
An increasing amount of research is conducted with respect to given healthcare by different organisations (ActiZ, 2011) (Stichting Nivel, 2012). However, none of these researches reflect the opinion on human rights

principles of the elderly client in long-term geriatric care. It is therefore of importance to know the experiences and opinions of the elderly client receiving long-term geriatric care in institutions.

Aim of the research

Research Objective

The research objective is to explore experiences and opinions of elderly clients, who make use of geriatric care in the form of institutional care, on their received care in relation with human rights.

Main Research Question

What are experiences and opinions of elderly clients on received care (in the form of institutional care) in relation with human rights principles?

Chapter 2: Conceptual Framework

In order to obtain insight on the opinions and experiences of the elderly clients on their received healthcare the core concepts underlying "Health and human rights" will be explored. These core concepts will be operationalized in the following paragraphs. Also relationships are shown in the conceptual model (figure 1) and will be explained in the following paragraphs.

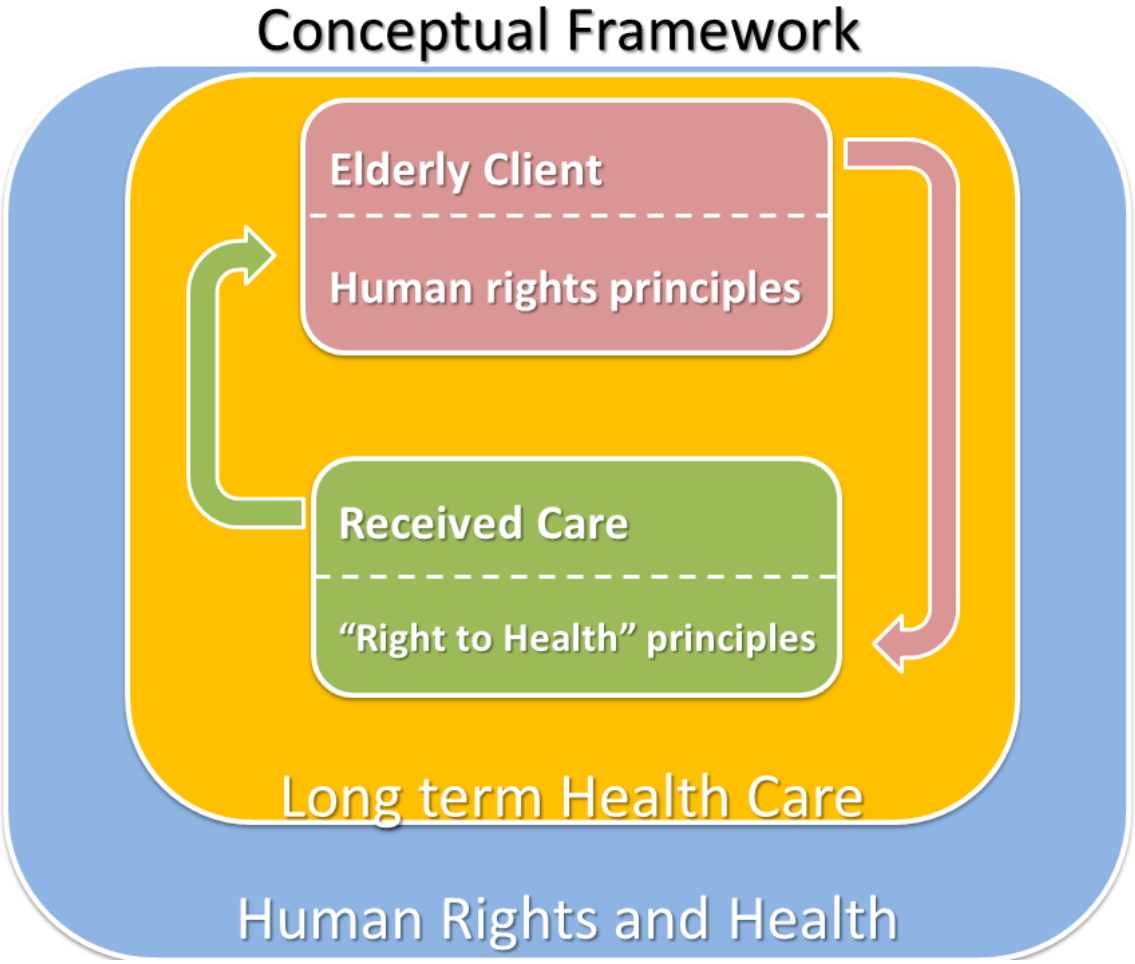

Figure 1. Conceptual Model

§2.1 Human rights and Health

Human rights and health is what this research is all about. This research aims to find out how the elderly client perceives received care (in the form of long-term geriatric care) in relation with human rights principles. In this case health can be described on what is done to achieve "the highest attainable health", the received care. Next to this, it is important to find out how received care affects the elderly clients' feeling of the concepts which underpin human rights.

To get a client perspective, the client is asked about the concepts of "right to health" principles on the received care. The pink arrow represents this relation. The green arrow represents how the received care in long-term geriatric care as a whole affects the clients' feelings of the human rights principles.

The yellow square 'long term healthcare' represents the environment which this research takes place. The blue square "Human rights and health" represents the context in which this whole research takes place.

§2.2 Long-term healthcare

The concept 'long-term healthcare' is the environment in which this research takes place. 'Long-term healthcare can be defined as: "A *range of services for people who depend on on-going help with activities of daily living caused by chronic conditions of physical or mental disability"* (General Assembly of the United

Nations, 2011). What is meant with long-term healthcare in the context of this research is specifically the geriatric care, in the form of institutional care. In the Netherlands the institutions which will be included in this research are the "*Verpleeg- en Verzorgingshuizen*" in throughout the Netherlands.
Even though the definition in the description of this concept defines that Long-term healthcare is a range of services for people who suffer of physical and/or mental disability; due to time restrictions this research will only focus on the elderly client who makes use of long-term care services and suffers from a physical disability.

§2.3 Definition of terms

Elderly Client

The 'Elderly client' who uses long-term healthcare in the form of institutional care in this research is:

- a person of 65 years or older
- suffers from one or more chronic diseases
- has one or more physical disabilities for which he or she receives care in an institution

Received care

In order to get experiences and opinions on how the elderly clients think about the main concepts of 'human rights and health' in an environment of 'long-term healthcare', it is important to ask about the concepts. The concept of "received care" refers to the healthcare services and goods the elderly client receives in the environment of long-term healthcare. 'Received care' is used in this research as a collective concept that includes the concepts which are the basic principles of "right to health". The collective concept 'received care' will be used to relate to and to ask about the elderly clients' experiences and opinions on the basic principles of human rights (fairness, respect, dignity, equality and autonomy).

§2.4 "Right to health" principles

Essential elements regarding the "right to health" are *Availability, Accessibility, Acceptability* and *Quality (AAAQ)* (Comittee on Economic, Social and Cultural Rights, 2000). These are important for clients to maintain the highest attainable health.

Accessibility

The concept "*Accessibility*" has four overlapping dimensions: *Non-discrimination*: health service should be accessible to all, even to the most vulnerable and marginalized parts of the population. *Physical accessibility*: health goods, services and facilities should be accessible to all groups of the population within safe physical reach. *Economic accessibility (affordability)*: healthcare should be affordable to all and poorer households should not have disproportionally higher expenses when compared to richer households. *Information accessibility:* everyone has the right to receive information concerning health issues. (Comittee on Economic, Social and Cultural Rights, 2000). In this research it is important to get to know what the opinion of the elderly client is on the accessibility in the institution they receive the long-term healthcare.

Acceptability

Acceptability is that health facilities, goods and services must be culturally appropriate and respectful of medical ethics (Comittee on Economic, Social and Cultural Rights, 2000). Within this research the concept can be defined as the cultural appropriateness and the medical ethics appropriateness of the institution where the elderly client receives their care. The question to be answered for the acceptability of received care is: Does the institution take cultural and medical ethics aspects in to consideration in the eyes of the elderly client?

Availability

Availability is the functioning of healthcare programs, facilities, goods and services. A sufficient amount should be provided by the state (Comittee on Economic, Social and Cultural Rights, 2000). In the context of this research it is the question what the elderly client thinks about the availability of goods and services within the specific institution they live in.

Quality

The concept *Quality* means that Health facilities, goods and services must be medically and scientifically appropriate and of good quality (Comittee on Economic, Social and Cultural Rights, 2000). In this research the perspectives and opinions of the elderly client will be asked with respect to the quality of goods and services provided by the institution which provides the healthcare.

§2.5 Human rights principles

Five concepts which underpin the principles of human rights and in this way which are interconnected with concepts described above are: fairness, respect, equality, dignity and autonomy (Equality and Human Rights Commission (EHRC), 2011). In this research, the elderly will be asked to elaborate on these concepts regarding received care. How does the received care affect their feelings of these principles?

Fairness

The concept *fairness* refers to the "right to a fair trial" (Department of Health (UK), 2008). In the context of this research, fairness means the possibility to fair process for dealing with problems about performance of healthcare staff or professional conduct. It is important to find out what is the elderly clients´ perspective is on available processes on this and how does it affect their feelings of fairness.

Respect

The concept *respect* refers to "the right to respect for family and private life, home and correspondence" (Department of Health (UK), 2008). Health professionals should respect diverse families, same sex couples with children and should avoid denying family access in the institutional care environment without a good reason. It is important to get to know if elderly clients are denied access to (specific) family members for any reason, and if so, how does this affect their feelings of respect.

Dignity

The concept of *dignity* refers to the first article of the UDHR *"All human beings are born free, equal in dignity and human right"* (Department of Health (UK), 2008)(United Nations (UN), 1948). In the context of this research, with dignity is meant the personal dignity of the elderly client. This is a dignity tied to self-respect and the identity of the person. Healthcare professionals should be aware and respect an elderly clients' dignity by seeing the elderly client as a person, not just as a body, taking private space and privacy of their body into account and giving the client time to make their own decisions (Walsh & Kowanko, 2002). The dignity of the elderly client can be violated as a result of external events – in particular, but not necessarily, through the deeds of other persons (in this case health professionals). What is important to find out is what affect the received care has on the elderly clients' feelings of dignity.

Equality

The concept *equality* refers to the "The right not to be discriminated against" (Department of Health (UK), 2008). Health services, goods and facilities must be provided to the elderly client without discrimination. Discrimination is any distinction, exclusion or restriction done on the basis of various grounds (e.g. to culture, age, belief, ethnic background) and has an impairment effect on the enjoyment of fundamental freedoms (World Health Organisation (WHO)). In the context of this research it is important to find out whether elderly clients feel if they are treated equally and have equal access to the health services and goods without discrimination.

Autonomy

The concept of *autonomy* refers to "right to respect for private life (Department of Health (UK), 2008).In the context of this research, autonomy is related to the identity and self-control of the elderly client (Barkay & Tabak, 2002). It entails the elderly clients' right to shape his life, influencing decisions about their daily routine and concerning their health and actively given the possibility to take part in their own living environment (Barkay & Tabak, 2002). Health professionals should give space for the autonomy of the elderly client and encourage decision making, especially if it concerns the elderly clients' identity or health. It is important in the context of this research to find out how does received care influence and affect the autonomy of the elderly clients.

§2.6 Sub research questions

The sub research questions are derived from previously described conceptual framework.

1. *How do respondents perceive the accessibility (non-discrimination, physical accessibility, affordability, information accessibility) of received healthcare?*
2. *How do respondents perceive the acceptability of received healthcare?*
3. *How do respondents perceive the availability of received healthcare?*
4. *How do respondents perceive the quality of received healthcare?*
5. *How does received healthcare affect their feelings about:*
    a. *fairness?*
    b. *respect?*
    c. *equality?*
    d. *dignity?*
    e. *autonomy?*

Chapter 3: Methodology

In the following section research methods will be described. First, the methodology of the literature study will be discussed. Subsequently, a description will be made on how the institutions and respondents were selected and approached for this research. Finally, a description will be given on the interview methods and methods which were used to analyse retrieved data.

§3.1 Literature study

To gain insight on the subject of the research, a literature study was conducted to get a comprehensive idea on what is known on geriatric care in relation to human rights. For this, different search engines were used (e.g. Google scholar, PubMed and Science direct) with search terms such as geriatric care, human rights and elderly care. National governmental websites were consulted for reports on elderly in the Netherlands (e.g. Nationaal Kompas of RIVM). Furthermore, generic websites on human rights were visited to find reports on human rights and "right to health" (e.g. UN, WHO and EHRC). Finally, Johannes Wier Foundation also provided literature in the form of books, folders and articles.

§ 3.2 Selection of institutions and respondents

In order to retrieve information about what elderly clients' opinions are on human rights with respect to right to health, semi-structured interviews and focus group interviews were held in geriatric care institutions in the Netherlands. Institutions were approached by a standard letter to ask whether or not to they wanted to participate in this research. The aim was to conduct fifteen interviews and three focus group interviews in three institutions in the Netherlands. An interview guide was developed in which the most important topics and questions were addressed (Appendix II & III).

Eligibility criteria for this research, it was important that respondents were elderly clients (65 years of age and above) who make use of geriatric care in an institution. Moreover, it was important that clients were able to express their opinions and experiences themselves. Therefore, elderly with dementia or other cognitive impairments were excluded from this research. Also, elderly who only receive care in the form of domestic or other non-health related care are excluded from this research. This research focuses on human rights in healthcare; therefore, respondents should have at least one chronic illness/disability (e.g. wheelchair bounded, amputation of a limb, diabetes etcetera) they receive care for.

Study population

In total, fourteen interviews and three focus group interviews with respectively three, five and four participants were conducted. Respondents who participated in this research ranged from the age of 65 years old to 94 years old of whom forty-four per cent were male and fifty-six was female. The level of education ranged from primary school to University degree. The time that the elderly clients were making use of healthcare services of the institution ranged from 4 months to 16 years. Also the health status of the respondents varied from complex/ severe disability to moderately disabled (Appendix IV).

§3.3 Interviews and analysis

The questions and topics in the interview guide (appendix II) and focus group guide were based on the theoretical framework and the research questions which were previously described. For the development of the interview guide, an interview guide of a similar study performed in England and the questions of the CQ-index were used as a baseline for the questions (Equality and Human Rights Commission (EHRC), 2011) (ActiZ, 2011). These questions were adjusted to fit the theoretical framework of this research. After the first four to five interviews, the interview guide was reviewed and adjusted based on the responses given.

During the interviews, voice recordings were made with informed consent of the respondents, with a mobile phone. The interviewing time for personal interviews ranged from 30 to 60 minutes and for focus group interviews, this ranged from 60 to 90 minutes. The structure of the interview was: The interviewer

introduced herself, explained the purpose of the interview, the aim of the research and insured absolute anonymity of the respondent. After the interview, a small summary of the interview was given to verify if the interviewer interpreted the answers correctly. Afterwards gratitude for participation was expressed by presenting the respondents with a gift card worth ten euro's.

During the interviews, no questions directly addressed the term human rights. This was to avoid pre-judgment and language respondents might not be familiar with. The emphasis of the questions was focussed on finding out opinions and experiences about the concepts described earlier in this document. The interview guide was developed in Dutch, since the interviews were held in Dutch. Though the interviews are conducted in Dutch, quotes are translated to English for purpose of this report.
Retrieved data of the interviews were transcribed by use of the computer program Express Scribe©. The individual interviews were coded with codes based on the concepts of the theoretical framework and research questions. Afterwards codes were interpreted and put into a matrix, by which these were compared and analysed. In the following chapter, results of this analysis will be discussed and quotes of what elderly clients' answered were used to give examples.

Chapter 4: Results

In the following chapter, the results of the conducted interviews and focus group interviews will be described. The structure will be as following: First the results of the interviews on the right to health will be elaborated, followed by the results regarding human rights. Quotes of personal interviews and focus group interviews are used to strengthen and further emphasize on these results. All interviews were conducted in Dutch and therefore all quotations have been translated to English.

§4.1 "Right to health" principles

Accessibility

On the dimension of physical accessibility, the majority of the respondents in the personal and focus group interviews were satisfied with the physical accessibility of their institutions. Though, there were respondents who did experience problems in this. One of the respondents wasn't able to visit her bathroom because of a defect of the electric wheelchair, which was not fixed yet. Another respondent experienced problem in reaching the cupboards in her kitchen, because she is wheelchair bounded.

The quote: "*This institution is really built on wheelchairs. Elevators and floors..*"/ "Deze instelling is echt gebouwd op rolstoelen. Liften en de vloeren.." is an example that shows that most wheelchair bounded respondents are satisfied with the physical accessibility of their institution.

Respondents find it important to be able to move around freely without problems. This increases their independence and autonomy in life. The respondents find it important to be as independent as possible.

On the economic accessibility of the institution the experiences and opinions differed and main concepts / themes in this were: lack of interest and value for money. The majority of the respondents showed a lack of interest for the financial accessibility of services. Usually the family of the respondents arranged their finances. The majority of the respondents interviewed in both the personal interviews and the focus group interview didn't even know what the costs were. Therefore, the majority does not have an insight and cannot say whether the proportion of what they pay and what they get is disproportioned or not.

The quote: *"The bill? That I have not seen, my son didn't show it to me, he said: Mom, you do not have to worry about your money because it is all paid for, so that's fine" /"De afrekening? Die heb ik nog niet gezien. En die heeft me zoon ook niet verteld. Die zegt dan: mam, ge hoeft u eigen over geld niet druk te maken want het wordt allemaal betaald dus dat is goed"* is an example of how it is arranged for the majority of the respondents in this research.

In the end, the majority of the respondents weren't worrying about expenses if everything is paid for, as one of the respondents said: *"You have to pay anyway, so I don't worry about that too much"/"Je moet toch betalen dus daar maak ik me niet zo druk om"*

Still for about one third of the respondents, it was important to get value for their money. These respondents pointed out that they thought that the value they got for what they paid was skewed in one way or another. For example, a respondent had the idea that what she paid for the care that she receives was too much while another respondent experienced that what he paid for the care was too little. This respondent clarified that she was willing to pay more to get an extra shower per week, but this possibility was not given. One of the wheelchair bounded respondents, who needs more care, mentioned that she also has to pay more for this. Also adjustments in her apartment were brought in to expense, while these are adjustments because of her disability. She expressed that she was not satisfied with this, but also stated that she thinks that in the future people will get less value for their money and everything will become more expensive.

With respect to the information accessibility of the institutions two themes were prominent within this concept: There was a lack of information but there was also good information. Respondents agreed that they get adequate information on possibilities in activities offered by their institutions. This was done in different ways per institution, varying from a weekly/monthly newsletter to personal information facilities.

Despite of the good information facilities within the organizations, there was a lack of information on what are the (human) rights which the respondents are entailed to. When respondents were asked if they got information about their patient rights and right to complain, the respondents almost unanimously answered *"No"*. The respondents said that they did not receive information about what their rights are.

Acceptability

Within the concept of acceptability, many items were discussed: cultural acceptability, religious acceptability, age-adjusted acceptability and medical-ethical acceptability. First, when the concept of cultural acceptability was discussed, the majority of the respondents were satisfied on how the care/daily activities are adjusted to their norms and values. Though one of the respondents disagreed and clarified that he does not feel at home at the activities, because it is more suited for demented people.

"There are quite a lot of demented people, which the activities are adjusted to. Well, I feel as if do not fit in, I do not feel at home there." / "Er zijn vrij veel demente mensen en de activiteit is er nogal op afgesteld, nou ik voel me daar niet bij passen, ik voel me daar niet bij thuis."

Second, religious acceptability is properly adjusted to the needs of the people. Over half of the people were satisfied about the religious services within their organization and made use of these on a regular basis. About one third of the respondents did not have a religious background and for this reason showed a lack of interest in the concept of religious acceptability.

Third, the majority of the respondents were satisfied with the age appropriateness acceptability of services given within their institutions. Although the majority was satisfied, one respondent experienced that some health workers do not take her age and her personal history into account.

Finally, respondents in this research could not give an extensive answer on how health workers work regarding medical ethics. Main issues for not being able to give an extensive answer to this concept were: Lack of knowledge, lack of interest and trust. The majority of the respondents expressed that they did not know what happened with their personal information, still they trusted the health workers work respectfully towards medical ethics, such becomes apparent from the following quote:
"Interviewer: How do they handle confidential information? Respondent: *I do not know, I think it's fine."/ "Interviewer: Hoe wordt er omgegaan met vertrouwelijke informatie? Respondent: Ik weet het niet, ik denk goed."*
Even though there was a lack of information for the respondents on how the health workers work with regard to medical ethics, the majority was not interested into further exploring whether or not this was the case and showed a lack of interest in this.

Availability

Within the concept of availability, the issues of reachability of personnel, quantity of personnel, waiting times and acceptance of the situation were on the foreground.
Regarding reachability of the personnel: a small majority of the respondents were satisfied with the reachability of the personnel in the institutions. This was about reaching the personnel when they are in need of care. The different institutions had different methods to reach the personnel, one of the institutions used phones while the other two institutions used an intercom system.
One of the respondents expressed the following on reachability and availability of personnel: *"When I ask, they do it immediately, then I can be bathed."/"Als ik het vraag, dan doen ze het onmiddelijk hoor,dan kan ik gewassen worden."*

Even though reachability was perceived as good, still respondents experienced that the quantity of available health workers was too low. Some of the respondents specified that lack of available personnel was only at night, others expressed that this was generally the case.
Long waiting times (15-30 minutes) were perceived as a problem for the majority of the respondents in this research, twice it was said that
"You can be dead and buried before they get here."/"Ge kunt dood en begraven zijn voordat ze er zijn."
The respondents who said this also explained that sometimes the health workers don't even show up when they call, and that they see them sitting outside, smoking.
In general respondents also expressed that the waiting time was dependent on the situation and the person providing the care, also they were expressing that the staff is doing their best and that they need to divide attention to a lot of people. The respondents accept their situation as it is, shortage of staff, long waiting times, and don't want to burden the health care workers with more stress.

Quality

The concept of quality is divided in two sub concepts, namely: quality of (care) services and quality of materials provided by the institution. First the findings in the quality of care services will be discussed. Within this sub concept opinions differed, both themes: quality of care and suboptimal care were experienced by the respondents. The division of opinions within these themes was about 50/50, about half of the research population was of the opinion that they received suboptimal care. One of the respondents was so dissatisfied that she complained at the complaint officer. She explained that
"Some of the health workers do not know how to operate a patient lift or are not allowed to smear medicated cream and just do this when they should not. They do it anyway" / "Nou er zijn erbij die geen tillift kunnen bedienen of zalf mogen smeren en het gewoon doen terwijl het niet mag. Die het toch doen."

This respondent also said that this problem mostly occurs with flex poolers or students still studying to be a health care worker. She also said that it occurs that new employees are not properly instructed when they start their new job and one of them even quit her job after one month because of this. Another respondent agrees on that some health workers are inexperienced and come to help him and sometimes say "*I have never bathed someone before*"/ "*ik heb nog nooit iemand in bad gedaan"*. But he does not experience this as a problem and experiences that the quality of the services is very good.

About half of the research population experienced that they get good quality care. But the respondents also put an emphasis on that quality of care is dependent on experience and the person providing the care. In all three institutions a lot of students and young people work. Some of the respondents prefer the older, more experienced staff, then the younger less experienced staff. Not only because of their inexperienced, also because of the mentality of these workers. One of the respondents in institution II said: *"Well, those girls who are doing there internship here, don't know how everything works, but well"/"Ja. Die meiden lopen nog stage, weten natuurlijk hoe alles rijlt en zijlt nog, maar ja toe".* This quote also illustrates that this respondent accepts the current situation, but is not specifically happy with it.

When looking at the quality of the materials provided by the institution, it was clear that a small majority was satisfied with the quality of these materials, but there also appeared to be a lack of action on defect materials. Several wheelchair bounded respondents expressed having a defect on their wheelchair and that they were still waiting for it to be fixed.

§4.2 Human Rights Principles

Fairness

With respect to fairness, which in this research refers to fair treatment while complaining, the following was experienced: some respondents felt that they were taken seriously when complaining and adequate steps were taken to better this. Some of the respondents experienced as if they were not taken seriously in their complaints.

"No, I got the idea that she was looking at as if she wanted to say, I don't give a damn. "/ "Nee, ik heb het idee dat ze me aan zat te kijken dat ze wilde zeggen, ik trek me der geen klap van aan." (a complaint about the food)
"It was taken seriously, also by the care coordinator"/ "Het werdt serieus genomen, ook door de zorgcoördinator" (a complaint about the health care services)
Respondents who did not feel taken seriously had complaints about the food services. Respondents having complaints about care services felt as their complaints were heard.
Also, a group of respondents felt as if there was no need to complain for various reasons some of them didn't want to be a nuisance, because the staff was already doing their best. Others just simply didn't feel the need to.*" I don't have complaints; the workers are doing their best. Why would I complain? "/ "ik heb geen klachten, mensen doen zo hun best. Waarom moet ik klachten hebben?"*

Respect

Regarding respect, which in this research is respect for family life, almost all respondents agreed that the institutions handle their relatives with respect, and does not, in any way deny the respondent from having their family life the way they want it. The following quote emphasizes that the respondents are very satisfied with the contact with the family.
"Certainly. No flaws for that matter, my family is very satisfied. " / "Jazeker wel. Geen enkele minpunt wat dat betreft, Mijn familie is erg tevreden."

Dignity

The concept dignity was carefully elaborated on with the respondents, since it is such an important aspect when you are dependent on other people. Dignity was divided in two sub concepts: internal dignity (how respondents feel about themselves and their situation) and external dignity (how others act upon the respondent). First, internal dignity will be discussed, followed by external dignity.
When talking with respondents about internal dignity the themes of independency and dependency were prominent. Respondents attach a lot of value to be as independent, as long as possible. The majority of the respondents experienced their feeling of being dependent due to their disability as a problem. This affected their internal dignity.
Regarding external dignity, the themes personal attention and respect were prominent. Respondents found it important to be treated with respect and receive enough personal attention from the health care workers. The majority of the respondents shared the opinion that got enough personal attention and respect from the health care workers. Even though the majority is satisfied with their dignity provided by healthcare personnel, they still expressed that also the amount of respect and attention was dependent on the person providing the care.
"I do not know what that nurse has against me, I sometimes wonder and ask. Why are you acting so weird? She did not give an answer. I am always helped as last when she works, only when she works. "/ "Ik weet niet wat die zuster tegen me heeft, en dat vraag ik weleens, wat hebt u feitelijk nou tegen mij? Wat doet u toch raar tegen mijn. Gaf ze geen antwoord. Ik wordt altijd het laatste geholpen bij haar, alleen bij haar"

Equality

Equality is the concept which regards to equal treatment without discrimination between patients. Within this concept, the respondents expressed that everyone in principle get an equal treatment. But respondents also expressed that they had a lack of knowledge on this concept, for they often expressed that treatment happens in the apartments, and therefore don't have an idea on this. Also with this topic, the respondents appear to trust the health care workers that they treat the patients equally. One of the respondent said that she does not compare her care with other elderly clients and that she is not like that. The following quote gives a general idea of how respondents feel about the concept of equality in this institution.
"Interviewer: When you compare your interaction with the health care workers and the interaction with other residents, do you feel that you are treated equally? Respondent: Yes, I do have that idea." /
"Interviewer : Heeft u het gevoel dat u als u contact met de zorg vergelijkt met u medebewoners, heeft u dan het gevoel dat u gelijk behandeld wordt? Respondent: ja, ik heb dat idee wel."

Even though a majority expressed that they think people are treated equally, they also expressed that they don't know this for sure; they understand when someone would be treated differently for the "greater good". As one of the respondents said: "*Some time ago, there was a women rolling in the corridors and screaming, but the staff was present, they said: we'll take her back home and we will give her some medication to become a bit quieter.* "/ "*Laatst ook weer toen reed ze hier en gaf ze rare brullen hoor ,maar dan zijn ze er wel bij, toen zeiden ze we nemen haar weer mee naar huis.En we geven dr wat dat ze een beetje rustiger wordt.* The fact that this woman was treated different was not a problem for this specific respondent.

Also in one institution, one of the locations visited had two types of rooms, single and double rooms. On which basis the rooms were appointed, was not clear to the respondents in this location. Single and double rooms might be an unequal treatment on its own.

Autonomy

Within the concept of autonomy, the most important themes which were spoken of by the respondents were decision making possibilities. These can be subdivided in decision making in care, decision making in daily schedule and decision making in their living environment.

Respondents were satisfied with their possibilities of decision making possibilities in their daily schedule and living environment (own apartment/room) but expressed that they experienced a lack in decision making possibilities within their own care.

What is an interesting fact is that the majority of the respondents want to be as autonomous/independent as possible, as described previously with dignity. Even though the respondent value this independence, a majority of the respondents show a lack of interest in decision making processes, they give some of their responsibilities regarding their autonomy away, like decorating the room and handling their paperwork. Relatives often do this for them.

Another contradiction which often occurred during interviewing is that respondents on one hand expressed that they are independent and make their own choices *"I decide everything for myself." / "Ik bepaal alles zelf."* .But on the other hand they said something in the context of "*Who am I?"/ "Wie ben ik?"* which indicates a loss of autonomy.

Despite of this, the majority agrees that they have enough control over their life, can make decisions, and stand up for themselves.

Next to what is described above, it was also interesting to see that during the interviews respondents did not want to complain about their situation. Based on their answers, there can be a couple of reasons why they do not want to complain: They were scared that management or personnel to find out that they were complaining, the respondents felt not important enough or they accepted the situation they are.

"Can you not say this to Tom?"/"Wil je dat niet tegen Tom zeggen?" [1] and *"Please, keep it between us, it shouldn't come out"/"hou het onder ons alsjeblieft, niet dat het hier bekend wordt"* are examples of quotes that indicate that these respondents were afraid that healthcare staff would find out that what they said and were afraid that it was have bad consequences, even when privacy was ensured.

The quote *"who am I"/"Wie ben ik?",* which was said by multiple respondents could indicate that they feel as if they are not important enough. What is also an indication that they might feel this way is that a lot of respondents expressed that there are many others that the healthcare workers need to help.

The quotes like *"I don't want to complain"/"Ik wil niet zeuren"* could also indicate that respondents might not be completely satisfied with some things (like for example quality of care services) but feel forced to accept the situation.

[1] For privacy reasons, a different name was used in this sentence

Chapter 5: Discussion and conclusion of the results

§5.1 Discussion

The following section attempts to link the found results and conclusions to the conceptual framework and the background of the research. These linkages will be critically reflected. The conceptual framework and background are used to interpret the results on "right to health" and human rights principals.

"Right to Health" principles

The results show that in the institutions of this research the physical accessibility is well adjusted to the elderly clients. Only some wheelchair bounded respondents experienced problems with the physical accessibility. This is also described in the Quick Scan report on quality of care (Nivel 2003). In this report 40% of patients in nursing homes expressed that there was not enough room for adequate use of wheelchair or patient lift. It can be argued that institutions might be less physically accessible for wheelchair bounded patients.
With regard to information accessibility, elderly clients feel that they are well informed about activities offered by the locations. Elderly do have the feeling that they receive little information about their rights as patients. It is not clear whether this information is given via other paths, for example via family members. Also, based on the results, it appeared that the majority of the patient seemed to lack interest on the concept of patient rights. There is no information found on patients' rights in the literature (ActiZ, 2011) (ActiZ, 2009). Though, the Quick Scan report of Nivel (2003) states that in 2001 results of quality and satisfactions surveys showed that patients get little information on the limits in care and where to go if they have any questions. The question is whether the provision on information about care possibilities and rights has been an issue between 2001 to present and to what extent. To get more extensive information on the aspect of information accessibility, especially regarding patient rights, more actors should be interviewed and organization of the information system will need to be evaluated.
As what was already found in the benchmark report of ActiZ(2011), the majority of the respondents experience that the availability of personnel is too little. Long waiting times and a shortage of staff are the biggest problems in availability. The effects of this is not discussed in the report of ActiZ(2011) but Bostick et al. (2006) states that there is a significant relationship between higher total staffing(especially licensed staff) and improved quality of care.
The results about the concepts of quality show mixed experiences. Overall the majority was satisfied with the quality of care as can also be found in the reports of ActiZ (ActiZ, 2011). In this research different institutions showed different results. Still an important aspect which was pointed out was the amount of pupils and the flexpool who do not have the experience and knowledge. This is degrading the quality of care. This is also found in the literature where Nivel (2012) states that the Dutch government wants to invest not only in the quantity of personnel but also in the quality by investing in education (Stichting Nivel, 2012).

Human rights principles

Respondents have different opinions about fairness. Interestingly, results show that respondents feel taken seriously depending on the subject of complaint. Respondents who felt as if they were not taken seriously in their complaints, mainly complained about the food they were served. The respondents that felt as if they were taken seriously mainly complained about the care services. A study on malnourishment in in the Netherlands showed that 6% of the patients in nursing homes are malnourished and 12% are at risk (Kruizinga et al, 2003).
Malnutrition can is associated with impairing quality of life and functional status, but also gives a higher chance of morbidity and mortality and in this way is an infringement on one's "right to health" (Smoliner et al, 2008). The way food is served and tastes can be a reason for fewer intakes and can lead to increased malnutrition. It is therefore important for the institution to also take the complaints about food seriously.

Respect for family life is clearly not an issue based on the experience of the respondents who participated in this research. Also literature of previous research in this field did not say anything about this aspect.

The results of the concept of dignity showed that with respect to internal dignity, the themes dependence and independence are very important. Similar to what was found in the results on that respondents' dignity is affected because their lack of independence, was described by Franklin et al (2006) as one of the themes that affects an older persons dignity (Franklin et al ,2006).

With respect to external dignity personal attention and respect were important subthemes. Similar to what was found in the report of ActiZ (2011) and the quick scan report of Nivel (2003), respondents felt as if they were properly approached with respect. Though the report of Nivel showed that in one of the studies described 25% of the patients experience that personnel did not have enough attention for them (ActiZ,2011)(Nivel, 2003) This is contradicting to what is found within this research, where only one of the respondents experienced a lack of attention.

Discrimination based on age/ belief/ cultural background does not appear to be an issue for this population of respondents. Though they do express that they also have a lack of knowledge in this, it appears that there might be discrimination in some ways. For example differences between one-person of double person room in one of the institutions. On what is the division of the room based? Respondents failed to answer this question. In the quick scan report by Nivel (2003) the following was said on this topic: In 2001, 85% of the people in nursing homes in the Netherlands weren't given the ability to choose whether they wanted a one-person or a double room (Nivel, 2003). There was no literature found if this aspect changed within the last years.

The concept autonomy shows some contradiction in the results. The respondents expressed that decision making is important as part of their autonomy. This was also the case in the research done by EHRC (2011). Still, respondents give part of their autonomy away by letting their relatives decide on for example the decoration of their apartment, or doing their paperwork.
The experience that there is a lack of decision-making possibilities in care, despite of the measures taken in the Dutch Geriatric (e.g. zorgleefplannen) indicates that these measures might not be acted upon adequately yet. The lack of decision making possibility in care was also found in the report on home care and human rights by EHRC(2011).
Also the "collective feeling" of not being important enough could indicate that the autonomy of the patients are not fully taken into consideration yet or adequately acted upon.

§ 5.2 Limitations/strengths of the research

In the following section, limitations and strengths of this research will be discussed.
This research has been done within the timeframe of 5 months. Therefore, the amount of elderly clients which could be interviewed was limited. This gives a limited view on how elderly clients perceive geriatric healthcare. To get more of an overview on what experiences elderly clients have in geriatric care, a larger sample of respondents should be interviewed in the future. What also can add and further strengthen scientific proof on this research subject is mixing qualitative research methods with quantitative research methods such as combining questionnaires and personal interviews and focus groups.
The selection of the institutions was done on the basis of institutions that were willing to cooperate. A lot of institutions were contacted to get involved with this research, but few responded and were willing to cooperate due to various reasons. This might increase bias within this research, because unwilling institutions might have produced different views/results.
Selection of respondents was not done at random, but mainly by health care staff, which provides a different image if people are selected at random. This was especially done because of limitations in time, but also there were limitations in the amount of effort the institutions wanted to give to conduct this research. It is advised that similar research conducted in this area in the future selects respondents at random, to reduce selection bias.

The interviewer had no medical background information about respondents, except for what was asked during the interviews. This was done to ensure the privacy of the elderly client. Though the information on what type of health care package (ZZP) respondents have or further information on what medical problems they have is of significance to get a more comprehensive image on the matter of human rights in geriatric care. What was also a difficulty within this research is that when respondents expressed that there is a "lack of staff", that there were no numbers known to actually assess if there was indeed a lack of staff.
One of the inclusion criteria is that the elderly clients participating in this research do not have any form of cognitive impairments. For this, the elderly clients were selected, though it is still possible that the respondents for this research may have slight cognitive impairments which are not diagnosed yet.
An advantage in this research is that it gives an idea on what elderly clients experience in long-term geriatric healthcare with regard to 'right to health' and human rights principles. This is a link which has not been connected before in Dutch research. The 'right to health' and human right principles are of such a significant importance which also the Dutch government dedicated herself to by signing the different treaties and resolutions on human rights and also should act upon. The economic and social Council of the United Nation expressed its concerns that many elderly clients are denied appropriate care and this research gives a more comprehensive insight in specific cases and experiences on this subject from the perspectives of the elderly clients.

§ 5.3 Conclusions

In the following section, the main conclusions of this research will be highlighted on which recommendation in the latter section are based on.
It is noticeable that based on the results of this research we are not talking about severe violations of "right to health" and "human rights" principles. These principles can also be found in the small daily things that elderly clients experience in receiving long-term healthcare services. In the end this is what is found in the results of this explorative research.
Within the "right to health" it seems that elderly know little about their rights. And know little about what the "right to the highest attainable health" entails. There is a lack of information on this topic or this information is not properly communicated. Also the availability of personnel lacks in well-trained health workers, reachability and the actual count of personnel is an issue. Also, younger healthcare workers tend to have a different attitude towards elderly people then the older experienced workers.
Within the "human rights" principles it was found that fair treatment of respondents was reflected in the fact that they were taken more serious if they made a complaint. Elaborating on the concept dignity showed that enough personal attention and respect was important to keep their dignity. Surprisingly, the concept autonomy shows a contradiction. Decision making on one hand seems to be very important for the elderly, however on the other hand, they also chose to be dependent in some ways. The feeling of not being important enough can partly explain this, since it was an important issue in this population.

§ 5.4 Recommendations

Based on the discussion and conclusions, recommendations to improve the human rights in long-term geriatric care will be discussed.
First, regarding "right to health" the concepts accessibility, availability and quality show issues in the experiences of the elderly clients. Regarding accessibility, conclusions show that elderly clients don't get information on their rights regarding their health. In fact, the awareness of their rights is low. It is recommended is to these elderly people to what their rights regarding "right to health" entail. By increasing elderly´s knowledge of their human rights (which can be a part of a human rights based approach in healthcare) will empower them to put a claim on these rights. When a claim is put on these rights, not only awareness will be increased in different actors in the network. Also actions should be taken to pursue these rights, which could resolve into positive effects on the quality of care. The empowerment of elderly clients might reduce the feeling as if they do not matter enough.
Secondly, next to increasing individual knowledge of elderly clients, general knowledge on how human rights in geriatric institutional healthcare need to be increased. This pilot study functioned as a starting

point for further research on what the relationship is of human rights and healthcare in this section of healthcare.

To be able to increase general knowledge on human rights in geriatric healthcare, extensive/on-going research is recommended. It is important to interview a bigger sample of elderly clients in more parts of the Netherlands to get a better representation of the Dutch population. To find out more about the relationship between human rights and long-term geriatric care, not only elderly clients should be taken into account in this research, but also other stakeholders like family, healthcare staff, management and health insurance. A mixture of qualitative research (e.g. interviews) and quantitative research (e.g. questionnaires) will increase the foundation of these future results.

Thirdly, in both the literature research as for the qualitative part of the research results showed that in the experience of the elderly client there is too little healthcare staff available. An evaluation of individual institution is recommended to solve this issue, for the different institutions have different structures and possibilities. In this, experiences of elderly clients must be seen as one of the most relevant stakeholder, as they are the ones experiencing the consequences of changes in the system and it is their health that is affected. Instead of a top down approach, in which common in the current healthcare system, a bottom up approach should be used. The elderly client should be the most important actor.

Finally, it is recommended that “right to health” and human rights principles will be integrated in current quality criteria for healthcare, for this is fundamental to every person universally and interconnected with every aspect of life and especially health.

Appendix

Appendix I Time Schedule of the research

In the following section the actions of the following five months research period will be discussed.

Weeks	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20
Research																				
Research Proposal																				
Data Collection																				
Data Entry																				
Analysing Data																				
Final report																				
Writing																				
Background & Problem field																				
Conceptual model & Research Methods																				
Results																				
Discussion &Conclusions																				
Recommendations																				

Research

Research proposal - Development of the extended research proposal is done from week 1 up to week 5. Development of this proposal included extensive literature research on what is known on the topic described previously.

Data Collection - The collection of data, which is done by conducting personal interviews and focus group interviews will comply a total of three months. Data collection will be done from week 6 up to week 17 of the research.

Data entry - In the period of week 7 to week 17 retrieved data will be entered and will be transcribed with use of the computer program Express Scribe©.

Analysing data – In the period of week 12 to week 18 retrieved data from personal interviews and focus group interviews will be analysed by coding of quotes and putting the codes into a matrix.

Final report – The final report will be written in the period of week 16 up to week 20 of this research.

Writing

Figure 2 shows the writing process of the research report. This process starts in week 1 by writing the background and continues till week 20 when the report is complete.

Appendix II Interview guide personal interviews

1. introductie (5 minuten)

• Dank voor de respondent voor het instemmen om deel te nemen aan het onderzoek.
• Geef een korte samenvatting over wat het onderzoek inhoudt en wat de respondent kan verwachten:

Goedendag dhr/mevr ... Mijn naam is Joceline Kranenburg. Ik ben studente master MPA aan de Vrije Universiteit te Amsterdam en doe voor de Johannes Wier Stichting dit onderzoek. Tevens ben ik ook fysiotherapeut in een verpleeg- en verzorgingshuis in Den Bosch. Als eerste wil ik u hartelijk danken voor uw tijd en uw deelname aan dit onderzoek. Graag zou ik het het interview willen opnemen om het zo accuraat mogelijk uit te werken. Gaat u daarmee akkoord? Alle antwoorden die u geeft zullen vertrouwelijk en anoniem worden behandeld. De Johannes Wier Stichting is geïnteresseerd in de vraag hoe oudere clienten de geboden ervaren. We voeren gesprekken met ongeveer 40 mensen ouder dan 65 jaar, woonachtig in Nederland in de provincie Noord Holland, die zorg ontvangen in de vorm van verpleeg en verzorgingshuiszorg. De bevindingen uit het onderzoek zullen gebruikt worden om aanbevelingen voor aanpassing van de scholing te doen voor de Johannes Wiers Stichiting.

Met behulp van uw informatie kunnen we anonieme voorbeelden (er worden geen persoonlijke gegevens gebruikt) geven in dit verslag voor aanbevelingen voor de scholingen.

In het komende uur, wil ik een informeel gesprek met u voeren waarin we het zullen hebben over de de geboden zorg die u krijgt en uw ervaringen en gevoelens daarbij. Ik ben geïnteresseerd in alles wat u hierover te zeggen heeft, vooral over hoe u u voelt over de geboden zorg en hoe dit u persoonlijk beinvloed. Er zijn geen goede of foute antwoorden, en ik ben geïnteresseerd in dingen die u positief ervaart over de geboden zorg en dingen die u wellicht negatief ervaart. Heeft u tot op dit moment nog vragen?

2. Achtergrond van de client (5 minuten)

Ik zou graag willen beginnen met de vraag of u een beetje over uw persoonlijke situatie en achtergrond zou kunnen vertellen zodat ik een beeld kan krijgen over uw omstandigheden.

- Persoonlijk:
  - Wat is uw leeftijd?
  - Bent u getrouwd (geweest)?
  - Heeft u kinderen?
  - Wat is uw hoogstvoltooide opleiding?

- Woonsituatie:
  - Woont u alleen?
  - Hoe lang woont u hier
  - Bevalt het wonen hier?

- Gezondheid en zorg:
  - Zou u kort kunnen omschrijven welke lichamelijke klachten u zorg voor krijgt?
  - Wat voor soort zorg krijgt u?

3. Geboden zorg (20-30 minuten)

Essentiële elementen met betrekking tot geboden zorg zijn beschikbaarheid, toegankelijkheid, aanvaardbaarheid en Kwaliteit (AAAQ) . Dit zijn pijlers waar de gezondheidszorg op gebaseerd is en zijn belangrijk voor u om de hoogst haalbare gezondheid te behalen en behouden.

Toegankelijkheid bestaat uit vier overlappende dimensies: Non-discriminatie: gezondheidszorg moet toegankelijk zijn voor iedereen. Fysieke toegankelijkheid: de gezondheid van goederen, diensten en voorzieningen moeten toegankelijk zijn voor alle groepen van de bevolking binnen veilige fysieke bereik. Economische toegankelijkheid (betaalbaarheid): de gezondheidszorg moet betaalbaar zijn voor iedereen en armere huishoudens moet niet onevenredig hogere kosten heeft moeten in vergelijking met rijkere huishoudens. Informatie toegankelijkheid: iedereen heeft het recht om informatie over zijn/haar gezondheid te ontvangen.

- Wat vindt u van de fysieke toegankelijkheid van de instelling/ dit huis?
- Wat is uw mening over de prijs/kwaliteitverhouding van de geleverde zorg in deze instelling?
- Wat vindt u van de informatievoorziening die u krijgt vanuit de zorginstelling? Bijvoorbeeld over activiteiten,mogelijkheden van zorg, informatie over uw rechten als bewoner en mogelijkheden om te klagen als u ontevreden bent.

Aanvaardbaarheid is dat wellness-faciliteiten, goederen en diensten moeten cultureel passend en respectvol van de medische ethiek (vertrouwelijke gesprekken blijven vertrouwelijk). Binnen dit onderzoek is het van belang het concept kan worden gedefinieerd als de culturele /leeftijd geschiktheid en de medisch-ethische aanvaardbaarheid van de instelling waar de oudere cliënt krijgt de zorg. De vraag die moet worden beantwoord voor de aanvaardbaarheid van de ontvangen zorg is: Heeft de instelling culturele en medisch-ethische aspecten in overweging te nemen om in de ogen van de oudere cliënt?

- Hoe waardeert u de afstemming van de zorg op u behoeften, normen en waarden? (geloof , leeftijd en persoonlijke normen en waarden.)
- Hoe wordt er omgegaan met vertrouwelijke informatie?

Beschikbaarheid is het de de beschikbaarheid van goederen en diensten binnen de instelling waar u woont. Voorbeelden hiervan zijn beschikbaarheid van zorg.

- Wat vind u van de beschikbaarheid van het personeel in de instelling?(verzorgenden en ander personeel)

- Kunt u personeel ten alle tijden bereiken?

Kwaliteit betekent dat de gezondheidszorginstelling waar u woont, goederen en diensten moeten van goede kwaliteit kwaliteit dient te zijn.

- Hoe waardeert u de kwaliteit en vakkundigheid van het verzorgend personeel ? (zijn ze op de hoogte van de problemen, nemen ze de gezondheidsklachten serieus?)
- Hoe waardeert u de bejegening en de omgang van het personeel naar u toe?
- Wat vind u van de kwaliteit van de gebruikte en geleverde apparatuur tijdens de verzorging (transferhulpmiddelen, rolstoel, rollator,verbandpantoffels)

4. Invloed van geboden zorg op de persoonlijke beleving (20-30 minuten)

Vijf belangrijke peilers van de persoon die u bent zijn: eerlijkheid, respect, gelijkheid, waardigheid en autonomie.Het is belangrijk voor ons om te weten wat voor invloed de geboden zorg heeft op u op het gebied van deze vijf peilers.

Eerlijkheid slaat op 'recht op een eerlijk proces ". In het kader van dit onderzoek, eerlijkheid betekent de mogelijkheid om een eerlijk proces voor het omgaan met problemen over de prestaties van het personeel in de gezondheidszorg of de beroepsregels.

- Weet u , als u klachten heeft over de zorg, waar u terecht kunt?
- Heeft u wel eens gebruik gemaakt hiervan ?
    - Zo ja, heeft u het gevoel gehad dat u serieus genomen werd in de behandeling van uw klacht en dat u eerlijk behandeld werd?

Respect verwijst naar "het recht op eerbiediging van gezins-en priveleven, thuis en zijn correspondentie". Gezondheidswerkers moeten respecteren diverse families, koppels van hetzelfde geslacht met kinderen en moet worden voorkomen ontkennen familie toegang in de institutionele zorg omgeving, zonder een goede reden. Het is belangrijk om te weten of ouderen klanten geen toegang tot (bepaalde) familieleden om welke reden dan ook, en zo ja, hoe beïnvloedt dit hun gevoelens van respect.

- Hoe wordt er in de instelling omgegaan met uw naasten/familie/betrokkenen?

Waardigheid betekent uw persoonlijke waardigheid. Dit is een waardigheid gebonden aan zelfrespect en de identiteit. Zorgverleners moeten waardigheid waarborgen door u te zien als een persoon, niet alleen als een lichaam, waarbij ze de privacy en de integriteit van uw lichaam respecteren en u voldoende ruimte geven om eigen beslissingen nemen. Luisteren zorgverleners aandachtig naar u?

- Wat vind u van persoonlijke aandacht die de verzorging u geeft.
- Wat vind u van de mogelijkheden om zelf mee te bepalen met betrekking tot u eigen zorg (Kunt u kiezen op welke momenten u zorg krijgt en welke zorg u krijgt?
- Wat vind u van de mogelijkheden die u geboden worden om zelf u dag in te delen?
- Heeft u de mogelijkheid de dag zinvol in te vullen? Wat vind u van de mogelijkheden?

Gelijkheid verwijst naar de "het recht om niet gediscrimineerd te worden". Gezondheid diensten, goederen en voorzieningen moeten worden verstrekt aan u, zonder discriminatie. Discriminatie is elke vorm van onderscheid, uitsluiting of beperking gebeurt op basis van verschillende gronden.

- Hoe waardeert u de afstemming van de zorg op uw behoefte?
- Heeft u het gevoel dat u, als u het contact met de zorg vergelijkt met u medebewoners, dat u gelijk behandeld wordt?

Zo ***Autonomie*** is gerelateerd aan de identiteit en de zelfbeheersing. U heeft het recht om uw leven vorm te geven, uw dagelijkse routine zelf te beïnvloeden en de gelegenheid te krijgen deel te nemen aan activiteiten.

- Wat vindt u van de mogelijkheden om u kamer/appartement in te richten?

5.Samenvatting en afsluiting (10minuten)

Dank de respondent wederom voor hun inbreng van het onderzoek. Geef een korte samenvatting van het interview om te controleren of de interpretaties van de antwoorden kloppen. Geef een klein presentje aan de respondenten als blijk van waardering.

Appendix III Focus group guide

Introduction (10 minuten)

- Achtergrond Informatie /doel van het onderzoek
- Doel/duur/structuur van de Focusgroep

Warming up (5-10 minuten afhankelijk van grootte van de groep)

- Naam
- Hoe lang woont u hier

Gebruikmakend van quotes door de mensen gezegd uit de specifieke instelling gesprek en discussie aangaan

Geboden zorg (30 minuten)

Essentiële elementen met betrekking tot geboden zorg zijn beschikbaarheid, toegankelijkheid, aanvaardbaarheid en Kwaliteit (AAAQ) . Dit zijn pijlers waar de gezondheidszorg op gebaseerd is en zijn belangrijk voor u om de hoogst haalbare gezondheid te behalen en behouden.
Toegankelijkheid bestaat uit vier overlappende dimensies: Non-discriminatie: gezondheidszorg moet toegankelijk zijn voor iedereen. Fysieke toegankelijkheid: de gezondheid van goederen, diensten en voorzieningen moeten toegankelijk zijn voor alle groepen van de bevolking binnen veilige fysieke bereik. Economische toegankelijkheid (betaalbaarheid): de gezondheidszorg moet betaalbaar zijn voor iedereen en armere huishoudens moet niet onevenredig hogere kosten heeft moeten in vergelijking met rijkere huishoudens. Informatie toegankelijkheid: iedereen heeft het recht om informatie over zijn/haar gezondheid te ontvangen.

- Economische toegangkelijkheid
- Informatie toegangkelijkheid
- Fysieke toegangkelijkheid
- Non discriminatie

Aanvaardbaarheid is dat wellness-faciliteiten, goederen en diensten moeten cultureel passend en respectvol van de medische ethiek (vertrouwelijke gesprekken blijven vertrouwelijk). Binnen dit onderzoek is het van belang het concept kan worden gedefinieerd als de culturele /leeftijd geschiktheid en de medisch-ethische aanvaardbaarheid van de instelling waar de oudere cliënt krijgt de zorg. De vraag die moet worden beantwoord voor de aanvaardbaarheid van de ontvangen zorg is: Heeft de instelling culturele en medisch-ethische aspecten in overweging te nemen om in de ogen van de oudere cliënt?

Afstemming van de zorg op behoefte ten aanzien van:

- Normen en waarden
- Leeftijd
- Geloof
- Omgang met vertrouwelijke informatie

Beschikbaarheid is het de de beschikbaarheid van goederen en diensten binnen de instelling waar u woont. Voorbeelden hiervan zijn beschikbaarheid van zorg.

- Hoeveelheid personeel
- Bereikbaarheid personeel

Kwaliteit betekent dat de gezondheidszorginstelling waar u woont, goederen en diensten moeten van goede kwaliteit kwaliteit dient te zijn.

- Kwaliteit van de diensten
  - Vakkundigheid en kwaliteit van de zorgverlening
  - Kwaliteit van de gebruikte goederen.

PAUZE INDIEN NODIG

Invloed van geboden zorg op de persoonlijke beleving (30 minuten)

Vijf belangrijke peilers van de persoon die u bent zijn: eerlijkheid, respect, gelijkheid, waardigheid en autonomie.Het is belangrijk voor ons om te weten wat voor invloed de geboden zorg heeft op u op het gebied van deze vijf peilers.

Eerlijkheid slaat op 'recht op een eerlijk proces ". In het kader van dit onderzoek, eerlijkheid betekent de mogelijkheid om een eerlijk proces voor het omgaan met problemen over de prestaties van het personeel in de gezondheidszorg of de beroepsregels.

- Mogelijkheid van klagen en hoe serieus men dan genomen wordt

Respect verwijst naar "het recht op eerbiediging van gezins-en priveleven, thuis en zijn correspondentie". Gezondheidswerkers moeten respecteren diverse families, koppels van hetzelfde geslacht met kinderen en moet worden voorkomen ontkennen familie toegang in de institutionele zorg omgeving, zonder een goede reden. Het is belangrijk om te weten of ouderen klanten geen toegang tot (bepaalde) familieleden om welke reden dan ook, en zo ja, hoe beïnvloedt dit hun gevoelens van respect.

- Omgang met familie/naasten en andere betrokkenen

Waardigheid betekent uw persoonlijke waardigheid. Dit is een waardigheid gebonden aan zelfrespect en de identiteit. Zorgverleners moeten waardigheid waarborgen door u te zien als een persoon, niet alleen als een lichaam, waarbij ze de privacy en de integriteit van uw lichaam respecteren en u voldoende ruimte geven om eigen beslissingen nemen. Luisteren zorgverleners aandachtig naar u?

- Externe waardigheid
  - Aandacht
  - Bejegening
  - Respect
- Interne waardigheid
  - Gevoel over eigen identiteit
  - Mogelijkheden om de dag zinvol in te delen

Gelijkheid verwijst naar de "het recht om niet gediscrimineerd te worden". Gezondheid diensten, goederen en voorzieningen moeten worden verstrekt aan u, zonder discriminatie. Discriminatie is elke vorm van onderscheid, uitsluiting of beperking gebeurt op basis van verschillende gronden.

- Gelijke behandeling van bewoners onderling

Autonomie is gerelateerd aan de identiteit en de zelfbeheersing. U heeft het recht om uw leven vorm te geven, uw dagelijkse routine zelf te beïnvloeden en de gelegenheid te krijgen deel te nemen aan activiteiten.

- Zelf keuzes kunnen maken:
  - Inrichting kamer

- Zeggenschap in eigen zorg (tijdstippen, soort zorg)
- Zelf de dag mogen indelen

5.Samenvatting en afsluiting (10minuten)

Appendix IV : List of participants personal interviews

Respondent	Male	Female	Age	Wheelchair bounded	Education	Verpleeghuis	Verzorgingshuis	Instution
1		X	65	Yes	MBO Hairdresser	X		Institution I
2		X	87	No	MULO		X	Institution I
3	X		78	Yes	University degree	X		Institution I
4		X	82	No	Primairy education		X	Instution II
5		X	87	No	MULO		X	Instution II
6		X	84	No	Primairy education		X	Instution II
7	X		69	Yes	Primairy eductation		X	Instution II
8		X	77	Yes	Pedicure diploma		X	Instution II
9 data not used for analysis		X	90	Yes	Primairy eductation			Instution I
10	X		90	Yes	Primary education		X	Instution I
11	X		87	No	Primairy education	X		Instution III
12		X	90	Yes	MULO	X		Instution III
13	X		88	No	Primary education	X		Instution III
14		X	79	No	Primary education		X	Institution III

Appendix V: List of participants focus group interviews

Institution I

	leeftijd	Man	Vrouw	Rolstoelgebonden	Verpleeghuis	Vezorgingshuis
1.	94	X		NEE		X
2.	88		X	JA	x	
3.	82		X	JA	x	

Institution II

	Leeftijd	Man	Vrouw	Rolstoelgebonden	Verpleeghuis	Verzorgingshuis	Uit de wijk
1.	78		x	NEE		X	
2.	92	X		NEE		X	
3.	86	X		JA	X		
4.	79	X		NEE			X
5.	81	X		NEE		X	

Institution III

		Man	Vrouw	rolstoelgebonden	Verpleeghuis	Verzorgingshuis
1.	83		X	NEE		X
2.	76	x		JA	x	
3.	87	X		NEE		x
4.	81		x	JA		x

Appendix VI: Selection of institutions

Institution I

Institution I is an institution which is situated in a big city in the southern part of the Netherlands. This specialised geriatric care institution contains 9 locations and gives all types of geriatric care (rehabilitation, long-term geriatric care, home care and psychogeriatric care). Elderly clients range from severely disabled to self-sufficient clients. In 5 of the locations elderly clients can receive long-term geriatric care who are solely physically disabled, 3 of these locations of this institution were willing to participate in this research. After the locations were contacted, healthcare personnel selected which clients were eligible respondents after which I personally contacted them to ask them for participating. A total of 5 respondents participated results with the personal interviews, of which 4 were used for data-analysis and 3 participated with the focus group interview.

Institution II

Institution II is an institution which is situated at the west coast of the Netherlands. It contains two locations where specialised geriatric care is given based on the personal need (rehabilitation, long-term geriatric care, home care and psychogeriatric care). The population in this institution varies from moderately disabled people to self-sufficient clients. One of the two locations participated in this research. The selection of the participants was done by the CEO of the institution. Together with the CEO and myself the participants were approached personally to ask for participation in this research. A total of 5 personal interviews were conducted of which 4 were used for this research. A focus group was conducted in which 5 participants participated.

Institution III

This institution is situated in the Northern part of the Netherlands and is similar with institution I. It contains 17 locations which are specialized in different sorts of geriatric care are given (rehabilitation, long-term geriatric care, home care and psychogeriatric care). After having had contact with the first geriatric doctor in line. Letters were set up and sent to eligible respondents which were selected health care personnel. After which, the clients gave consent to participate or not. The researcher contacted the respondents personally to make an appointment with them for the personal interview/focus group interview. A total of four personal interviews were conducted and four respondents participated in the focus group interview.

Appendix VII: Matrix analysis

Institution I

	Respondent 1	Respondent 2	Respondent 3	Respondent 10	FOCUSGROEP 3 personen
ACCESIBILITY					
Physical accesibility	-Beperkt door rolstoel ivm mankement Dissatisfied/acceptance of situation	• Weet niet, is nog niet overal geweest binnen het huis lack of interest	• Goede bereikbaarheid met rolstoel Satisfied	Goede bereikbaarheid rolstoel Satisfied	Resp1+resp2: goede physical accessibility Resp3: Ik moet geduwd worden.
Economic accesibility	• Geen inzicht in eigen kosten • Prijs kwaliteitsverhouding scheef • Geen extra mogelijkheden zorg voor extra geld Value for money/ lack of interest	• Prijs kwaliteitsverhouding scheef. • Mist huishoudelijke apparatuur (vriezer, zonnescherm etc) Value for money /missing basic lifesupplies	• Prijs kwaliteitsverhouding scheef (betaalt te weinig) • Weet niet wat de medische kosten zijn Value for money/lack of information	Weet niet, dochter regelt het Lack of interest	-niet besproken
Information accesibilty	• Activiteiten: Nee • Patientrechten: Nee • Recht op klagen: Nee Lack of information	• Activiteiten: Goede informatie • Patientenrechten: Geen informatie • Recht op klagen: geen informatie. Doet dit via CR. Lack of information patient rights/ Finding other pathways	• Geen informatie kosten> zou graag een overzicht zien. • Activiteiten: Goede informatie • Patientenrechten: Geen informatie • Recht op klagen: informatie ontvangen over • klachtenlijnen etc Lack of information costs/ lack of	Geen informatie over rechten Goede informatie activiteiten Lack information rights	Resp2:Activiteiten: goed Resp3: we krijgen af en toe wel een brief, en wat voor rechten heb je. Je hebt recht voor verzorging. De mensen hebben geen tijd om met ons een praatje te maken. Lack of knowledge on what are rights

			information patient rights		
Non-discrimination					
QUALITY					
Quality services	• Kwaliteit van zorg omlaag • Lang wachten • Verwaarlozing door lang wachten • Veel leerlingen en flexpoolers met weinig kennis • Vakkundigheid verschilt per persoon • Personeel slecht ingewerkt • Geen adequate acties op gezondheidsproblematiek (medicijngebruik/aanvraag) • Afspraken worden niet altijd nagekomen Bad professional knowledge/ quality dependent on person/ Waiting time	• Fijne verzorging • Wordt veel dingen vergeten (Bijv curven) • Gevolg: Afspraken worden niet nagekomen • Zorg kan beter • Meesten op de hoogte van gezondheidsproblematiek • Geen adequate omgang gezondheidsproblematiek (te laat medicijnen) External dignity / Suboptimal care /not held to appointments	• Vakkundigheid: Goed opgeleid, missen soms praktische ervaring Suboptimal care/lack of experience personnel	Vakkundigheid: afhankelijk van de medewerker Quality dependent on person	Resp3: de ene dag heb je leerlingen aan je bed. Kwaliteit is afhankelijk van ervaring Quality dependent person/ suboptimal care Resp2: ze moeten natuurlijk leren, dat snappen we wel, maar dat kan wel eens moeilijk zijn. Veel zelf goed in de gaten houden. Suboptimal care Resp1: Goede kwaliteit Good quality care
Quality Materials	• Accu tilliften weleens leeg • Rolstoel mankement Lack of action on defect materials	• Mankementen aan het appartement • Goede kwaliteit materiaal (zelf betaald) Lack of action on defect materials /Good quality own bought materials	• Rolstoel mankement Lack of action on defect materials	Batterij tillift wel eens leeg inadequate recharge batteries	Resp2: Goede stoel Resp3: er zijn te weinig liften. Too little resources for care Resp1: ze kunnen niet voor iedereen een lift kopen. Ze moeten maar op hun beurt wachten.
AVAILABILITY	• Slechte bereikbaarheid personeel • Buiten koffie drinken • Lang wachten	• Slechte bereikbaarheid personeel • Buiten koffie drinken • Lang wachten (na 15-30 min	• Ooit wel eens lang wachten • Over het algemeen goede	Slechte bereikbaarheid Lang wachten geholpen wordt > ook weer afhankelijk wie er op de	Resp1: bij mijn vrouw duurt het lang Res3: Slechte bereikbaarheid, er kan ook iets gebeuren, soms geven

	• Te weinig personeel, m.n. 's avonds • Gevolg: Personeel is gejaagder Lack of reachability/too little personnel/breaks more important then care /stressed personnel	pas) • Te veel wisseling personeel Lack of reachability/breaks more important then care/switches in personnel	beschikbaarheid • Bewoner moet aanpassen op hoeveelheid personeel • Efficiency belangrijk> geen onnodige dingen • Material: heeft wat hij nodig heeft Acceptance of situation	afdeling staat Lack of reachability/ dependent on the person	ze helemaal geen antwoord. Resp 2: ze nemen de bellen niet aan. Ik heb de po nodig gehad om te drukken, maar ze kwamen te laat. Long waiting times/lack of reachability/suboptimal care
ACCEPTABILITY					
Cultural	• Verschillend per persoon Dependent on person	• Niet altijd afgesteld op persoonlijke wensen • Persoonlijke zorg naar wens Contradiction	• Goede afstemming persoonlijke wensen • Activiteiten: teveel afgestemd op dementerenden (HOEMPA WEEK) • Voldoende ruimte voor dingen die hij belangrijk vindt • No participation in activities	Prima	Resp2: Goed aangepaste activiteiten. Goed aangepaste zorg Responsive
Belief	• Ja • Satisfied	• Niet goed afgestemd dissatisfied	• Niet goed afgestemd > Teveel focus katholieken Dissatisfied	1x p week een mis, goed afgestemd Satisfied/lack of interest	Resp: er is elke week een mis
Age	• Personeel speelt goed in op leeftijd Satisfied	-	-	-	
Medical Ethical	-Vertrouwd erop dat hier goed mee omgegaan wordt, Weet het niet zeker	• Wordt goed mee omgegaan Lack of interest	• Wordt goed omgegaan met vertrouwelijke	Weet niet, denkt dat hier goed mee omgegaan wordt	Resp2: Ik neem aan dat dingen goed gerapporteerd worden. Trust/lack of knowledge/ lack of

	Lack of knowledge/trust		informatie satisfied	Trust/lack of knowledge/lack of interest	interest Resp3: dossier lag eerst op de kamer, maar ligt nu op de zusterpost. Satisfied
DIGNITY					
Internal	• Zoveel mogelijk zelf blijven doen Independence • Is graag op tijd, maar afhankelijk van personeel Independence • Wordt niet altijd verzorgd zoals ze dat wil Human rights • Vindt het belangrijk om uit de kamer te zijn Idependence	• Mevrouw maakt grapjes met personeel, vind zichzelf een halve gare Dignity of identity • Fysiek goed blijven Physical health • Wie ben ik? Diginity of identity	• Dichtbij relatie > Thuisgevoel Feeling of home • Doe dingen voor het gemak van personeel Dignity of identity	Ik kan weinig dependence	Resp2": natuurlijk satisfied Resp3: ik moet alles vragen Idependence
External	• Wordt niet altijd geluisterd naar wat mevrouw wil Human rights/disrespect • Tegenspraak/ontkenning van personeel Human rights/disrespect • Weinig aandacht van personeel • Human rights/insensitivy	• Personeel maakt grapjes met mevrouw • Personal attention • Communicatie niet altijd goed afhankelijk van persoon • Dependent on person • Goede bejegening een enkelling uitgezonderd Human rights • Goede aandacht Satisfied	• Er wordt geluisterd naar vragen • Serieus genomen • Over algemeen goede bejegening, scheelt per persoon Human rights/ satisfied	Er wordt geluisterd naar wat er gevraagd wordt Goede bejegening personeel Personal attention/insensitive for needs/satisfied	Resp2: goede bejegening , toch vind je die een beetje aardiger Dependent on the person Resp3: goede bejegening over het algemeen. Satisfied
AUTONOMY	• Geen inbrengmogelijkheden zorg voor extra geld Lack of decision making	• Wie ben ik? Lack of autonomy • Komt voor zichzelf op	• Zoveel mogelijk zelf doen participation	Weinig inbrengmogelijkheden zorg Lack of decision making	Resp2: je zit hier, en ik zit liever thuis natuurlijk Loss of home

	options in care • Zoveel mogelijk zelf doen/bepalen. Heeft het gevoel dat ze dit doet • • Komt voor zichzelf op door achter problemen aan te gaan Self-respect	• Hospitalisation (ze doen zelfs de haren kammen)Vraagt ook simpele dingen aan personeel (bv batt in weegschaal) • Zelf inrichten woonruimte: dochter heeft het gedaan. Decision making by children/ lack of interest	• Goede inbrengmogelijkheden zorg Satisfied decisionmaking • Wil vroeg geholpen worden. Calculeert eigen inbreng in zorg • Zelf inrichten • woonruimte: Ja	options in care Familie heeft kamer ingericht Decision making by children/lack of interest	Resp3: kan aangeven wat en verandering aanbrengen in dagritme. Zorg wordt niet zelf ingedeeld Resp1: deelt zijn dag zelf in en vindt dat hier voldoende mogelijkheden in zijn. Satisfaction on decisionmaking
RESPECT	• Weet niet, geen klachten gehoord Respectfull of family	• Goed contact met familie Respectfull of family	• Goed contact met Familie • Respectfull of family	Goed contact met familie Respectfull of family	Unaniem: Goede omgang met familie Respectfull of family
EQUALITY	• Gelijke behandeling van bewoners Equal treatment	• Vergelijkt niet • Lack of interest	• In principe gelijke behandeling > uitzonderingen daargelaten Equal treatment/ dependent • Van bewoners naar personeel toe unequal treatment towards personell	Denkt een gelijke behandeling met andere bewoners te hebben Lack of interest/ lack of knowledge (on rights)	Resp1: kan ik niet over oordelen Lack of knowledge(on rights) Resp3: gelijke behandeling Equal treatment
FAIRNESS	• Tevredenheid over mogelijkheden en over eerlijke behandeling van haar klacht (zorg) Sensitivity on complaints	• Klagen helpt niet, lul maar raak (eten) Lack of knowledge on rights/ insensitivity about complaint	• Klagen helpt niet, wordt niets mee gedaan (eten) • Insensitivity about complaint	Geen klachten gehad Satisfaction	Resp3: met een klacht kun je naar de zorgcoordinator. Heel goed omgegaan met de klacht. Sensitivity about complaints

Institution II

	Respondent 4	Respondent 5	Respondent 6	Respondent 7	Respondent 8	Focusgroep 5 personen
ACCESIBILITY						
Physical accesibility	• Goede physical accesibility Physical accessible	• Goede physical accessibility Physical accessible	-Goede physical accesibility Physical accessible	• Goede physical accesibility Physical accessible	• Mevrouw kan niet overal komen en kan niet overal bij, zoals de hoge kastjes van de keuken • Problemen met de liften naar het fitnesscentrum te komen Physical barriers/ lack of adjustments to wheelchair bounded patients	Unaniem: goede fysieke toegankelijkheid, R3: "*Met de rolstoel kan ik overal goed komen*" R4: zelf toegankelijkheid gezocht. Is hier tevreden over. "*Het is een vrije toegankelijkheid*" Physical accesible
Economic accesibility	• Krijgt zakgeld, maar heeft weinig invloed op de kosten want het gaat via de zorgverzekering, belangrijk is dat mevrouw kan doen en laten wat ze wil . independence	• Weet niet, zoon regelt financien Lack of interest/ dependence	• Weet niet, Neef gaat over financieen Lack of interest/ dependence • Rolstoel is zelf aangeschaft, veertienhonderd euro. Lack of knowledge on possible reimbursements	• Goede prijs/ kwaliteitsverhouding van wat dhr betaalt en welke zorg hij krijgt value for money	• Financiele dingen (belasting) worden geregeld door een boekhouder • *"Heb je extra verzorging nodig dan komt het op een lijstje en dan moet je ervoor betalen."* Dit ervaart mevrouw als vervelend	R5: tevreden over de verhouding R3: Je betaalt naar vermogen, hangt af van indicering. Weet niets van de prijs Value for money R5: Nooit van een prijs gehoord,daar heb ik vrede mee Lack of interest/acceptance

					• *"Uhh, zou je dat of dat voor me willen doen, moet je betalen. Dat komt er allemaal bij dus die kosten komen steeds hoger te zitten."* Value for money • Mevrouw had een nieuwe kraan nodig omdat ze er niet bij kon, moest hiervoor betalen. Mevrouw was het hier niet mee eens "*ik krijg van jou een kamer en jij moet ervoor zorgen dat ik erin kan wonen."* Lack of adjustments to wheelchair bounded patients/physical barriers	situation R1: Er wordt betaald naar vermogen, maar *"mensen zonder pensioen kunnen soms eigenlijk niet rondkomen met wat ze moeten betalen"*
Information accesibility	• Goede informatie ove r activiteiten • Good information activities	• Goede informatie over activiteiten • Geen informatie over rechten, als mevrouw een probleem heeft gaat ze naar de zusters • Good information activities/ Lack	• Goede informatie over activiteiten • Geen informatie over rechten en klachten • *" ik heb geen klachten, mensen doen zo hun best. Waarom moet ik klachten hebben?"*	• Goede informatie over activiteiten • Weinig informatie rechten als patient • Weinig informatie over eigen gezondheid. >Dhr kon ineens niet	• Goede informatie over activiteiten • Geen informatie over rechten en klachten • Good information about activities/ lack information	Goed informatie voorziening R1: Als je binnenkomt wordt er te weinig informatie gegeven (als je er nieuw komt wonen, R2 is het hiermee eens.

		information rights/lack of interest	• Good information activities/ Lack information rights/	meer staan, "wat mankeert er nou aan dokter?" "Dokter: De tijd moet het hebben", zou hier wel meer over willen weten. • Good information activities/lack of information about health	on rights	Niemand had hem iets verteld van hoe alles werkt. Good information Geen informatie over rechten als patient R3: *"alles wat ik zelf kan doen ik zelf en de rest krijg ik van jullie"* Lack information rights
Non-discrimination	• Weinig/geen info over non-discrimination			• Dhr denkt dat ie voorrang heeft gekregen op het krijgen van een kamer omdat zijn familie in de instelling werkt Inequality	"*ik krijg van jou een kamer en jij moet ervoor zorgen dat ik erin kan wonen."* Lack of wheel chairbounded adjustments	
QUALITY						
Quality services	• Goede kwaliteit • Vast/ wat ouder personeel is goed, jonger personeel moet wat aanpoten, staan soms te niksen op de gang • *"Ja. Die meiden lopen nog stage, weten natuurlijk hoe alles rijlt en zijlt nog, maar ja toe".* • *"Ja, ja echt. Dat wij hier kwamen wonen. Toen was er ook meer verplegend personeel hoor"*. Over de	• Goede vakkundigheid personeel • vragen adequaat naar gezondheidsproblematiek • *"Heb je nog hoofdpijn? Of zakt het een beetje? Ik ging toen al naar dokter stol, twee keer in de week. Ja en dan, ze vroegen ook wel iedere keer."* • *Personal attention*	• Goede vakkundigheid personeel • Tevreden over services Good quality	• Goede kwaliteit zorg • *"je wordt helemaal bediend van A tot Z "* • Goede vakkundigheid personeel Good quality/personal attention	• Geen goede timing met prikken insuline (verleden) • *"En dat wordt half een soms, maar dan kwamen ze om elf uur, we komen u even prikken. En dan kreeg ik om half een pas te eten, die afstand was veelste groot."* • Weten het verschil niet tussen curven	Goede kwaliteit verzorging R5: aandacht van de verzorging R4: goede verzorging, gastvrij Good quality/personal attention

	hoeveelheid personeel • Goede vakkundigheid personeel Quality dependent on person/ younger personnel have lack of knowledge/ lack of personnel				en bloedonderzoek • "*Nou ze zeggen zo, is die bloedonderzoek ook weer klaar, ik zeg bloedonderzoek? Je bent toch niet aan bloedonderzoeken ? Ja! Ik zeg nee dit is curven voor mijn suiker."* • Veel leerlingen, deze hebben geen goede vakkundigheid • *"De leerlingen ja. Ik zeg altijd, waarom komen jullie altijd met z'n tweeen? Vinden we gezellig. Nee is om te leren toch? Die andere moet toch leren?"* Disrespect/lack of knowledge personnel	
Quality materials	• Niet van toepassing	• Niet van toepassing	Niet van toepassing	• Tevreden over de kwaliteit van de tilliften • Goede kwaliteit stoel • Rollator gekregen van de overheid.	• Niet tevreden, rolstoel moet versteld, echter mevr wacht al 4 weken. Lack in service for wheelchair	Goede kwaliteit materiaal Good quality goods

				Goede kwaliteit Good quality goods		
AVAILABILITY	• Wanneer ik ben dan komen ze • Vind dat er te weinig personeel is Lack of personnel	• Goede beschikbaarheid personeel, uitgezonderd 's avonds • Personeel is dag en nacht bereikbaar • Korte wachttijf voor dat ze er zijn Lack of personnel at night/ good reachability/short waitingtime	• Goede beshikbaarheid van de zorg • Goede bereikbaarheid zorg (ten alle tijde) Good availability/good reachability	• Goede beschikbaarheid personeel. • Dhr kan bellen voor zorg maar doet dit nooit. • Geen beschikbaarheid van andere disciplines binnen de instelling Good availability/ lack of interest in possibilities care/ lack of knowledge in possibilities care	• Goede beschikbaarheid personeel *"Maar nou als ik het vraag dan doen ze het onmiddelijk hoor, en dat ik gewassen kan worden."* • Goede bereikbaarheid personeel. • Good reachability/ good availability	R3: Laatst moest meneer na het bellen 20 minuten wachten totdat personeel kwam, komt gelukkig niet vaak voor Rarely Long waiting time R2: Wachttijden kunnen weleens een probleem zijn, varieert met een minuut of 10 Sometimes long waiting time/ collective feeling R3: Ze kunnen via de intercom vragen en inschatten hoe noodzakelijk is om te komen. Dit doet verzorging adequaat Good reachability R1: Mevrouw was laatst gevallen, heeft toen gebeld (7 uur s'ochtends met de overdracht. Heeft 3 kwartier gebloed tijdens het wachten. Andere mensen moesten daarna wachten tot ze gewassen konden

						worden, mevrouw vond dit erg vervelend -Op sommige momenten is er meer verpleging nodig. Collective feeling/ burden to others
ACCEPTABILITY						
Cultural	• Zorg is goed afgestemd op persoonlijke behoeften van mevrouw Sensitivite for needs • Wordt goed ingespeeld op normen en waarden vanuit de zorg Acceptable for norms and values	-goede afstemming op normen en waarden Acceptable for norms and values	-goede afstemming op persoonlijke normen en waarden Acceptable for norms and values	• Goede afstemming op persoonlijke normen en waarden. Dhr heeft niets te klagen, er wordt overal rekening mee gehouden Acceptable for norms and values	• Mevrouw wilt een stoeltje in de douche hebben ivm uhv staan, " *maar ze zijn niet enthousiast.*" • Activiteiten volgens mevrouw niet voldoende acceptable ivm rolstoel. Lack of service/ Lack of wheelchair adjustments	Goede afstemming Good acceptability
Belief	• Goed • Good acceptability	• Goede afstelling geloof, voor elk geloof, eens per maand kan mevrouw naar de mis • Good acceptability	• Goed, mevrouw gaat eens per maand naar de mis • Good acceptability	• Dhr is niet gelovig Lack of interest in belief	-nvt	R1: het is veel beter geworden Ze zijn nu bezig met een viering te organiseren Acceptability improved Bij deze viering wordt er niet gekeken naar je geloof, iedereen is welkom
Age	• Zorg is goed afgestemd op leeftijd				• Weinig initiatief vanuit verzorging	-

Medical Ethical	*"Heeft u iets van een zorgleefplan of een dossier waar ze alles in opschrijven? Ja. Ja. Wil je dat zien?"- dossier ligt ook op de kamer, iedereen zou erin kunnen kijken* Lack of right to privacy	• Mevrouw denkt dat hier wel goed mee omgegaan wordt • Lack of knowledge / lack of interest	• Hier wordt goed mee omgegaan	• Hier wordt goed mee omgegegaan	• Vind dat er niet goed omgegaan wordt met vertrouwelijke informatie, als er iemand is overleden dan wordt het de volgende dag bij de koffie besproken. Lack of respect of medical ethics	-
DIGNITY						
Internal	*"Nou af en toe wel hoor. Ja... Af en toe is het hopeloos met me. Maarja toe dat gaat ook weer over. Maar ehh .ja .. Maar ja wie ben ik."* - geeft aan niet altijd even veel levenslust te hebben. Zest for life		• Vindt het belangrijk om zelf te kunnen bepalen wat ze doet • independence	• Vindt zichzelf een makkelijke man. "Ik ben een hele makkelijke man." Charactar • "Tis ook hoe je zelf bent he", met betrekking tot een mening vormen over de zorg • Dhr moet nu meer geholpen worden in verband met staan, heeft een hekel aan afhankelijk zijn • Dependence	• Vind haar handicap moeilijk te accepteren Depence • *" En ik ken toch niet ieder moment die meiden roepen om te zeggen wil je dat ding omhoog doen"* dependence • Heeft niet altijd zin in activiteiten • *"Nou ja maar dan heb je dan altijd geen zin in"* Zest for life • *"Je raakt er nooit aan gewendt hoor."* Adjustment to dependence	R2: Niet gewend voor zichzelf te zorgen, *"Ik ben een stuntel"* Selfrespect R1: Sommige mensen voelen zich erg eenzaam, moeilijke acceptatie van klachten en afhankelijkheid Dependence/loneliness

External	• Goede bejegening personeel, vroeger werd er wel meer gelachen • Personeel luistert naar vragen die gesteld worden Personal attention/ respect	• Goede bejegening personeel • Personeel is lief • Ze luisteren naar je als je een vraag hebt, proberen deze te beantwoorden • Voldoende aandacht • Kan zelf niet bij medicatie Personal attention/ helpfull	• Personeel is lief	-goede bejegening personeel Respect	• Bejegening personeel is goed maar "*Sommigen doen het beetje op eigen manier.*" Dependent on person/ respect	R1: Er is behoefte voor kwaliteit aan leven behoefte voor sommige mensen om wat meer te kunnen praten, dat gebeurt te weinig Lack of personal attention -Personeel is attent en aardig Respect
AUTONOMY	• Eerst een tweepersoonsapparteme nt, toen man overleed moest mevrouw verhuizen naar een 1persoonskamer. Lack of decisionmaking • Mevrouw heeft altijd al in de instelling willen wonen • Ik doe alles zelf Independence • Ik wil kunnen doen en laten wat ik wil Dignity of identity • Goede mogelijkheden voor inrichten van eigen kamer Good decisionmaking living enviroment	• Weinig inbreng over tijdstip van verzorgen, er zijn ook nog vele anderen Lack of decisionmaking in care • Voldoende ruimte om de dag zelf in te delen. • Goede mogelijkheden om zelf de kamer in te richten, zonen en schoondochters hebben dit gedaan Enough decisionmaking in living environment/ lack of interest	• *"Nou ja persoonlijke wensen, wat heb ik voor wensen?"* Dignity of identity • Personeel houdt rekening met persoonlijke wensen, zoals bijvoorbeeld, wat mevr nog zelf kan bij verzorging • Goede mogelijkheden om te bepalen hoe de dag wordt ingepland Possibilities in decisionmaking dayplanning • Goede mogelijkheden om kamer zelf in te richten Enough	• Als dhr vragen heeft proberen ze deze zo goed mogelijk te antwoorden. • Je krijgt verzorging op bepaalde tijden in verband met vaste tijden voor het eten. • Weinig inbreng over wanneer de zorgmomenten zijn. Lack of decisionmaking in care • Goede mogelijkheden om dag zelf in te vullen *"je bent geen gevangene natuurlijk he ".* • Good possibilities in decisionmaking	• Mevrouw kan zelf dag indelen: • Bijv. Mevrouw gaat naar braderie en neemt haar insuline en medicijnen van vijf uur mee en neemt deze zelf in . Good possibilities in decionmaking dayplanning • Kon haar huisdier meenemen, zou echter geen nieuwe kunnen nemen als deze doodgaat. Possibilities Pets	R2: Vragen valt niet mee, dan moet ik gewassen worden "*dat valt niet mee*" Acceptance of dependence *R3: "alles wat ik zelf kan doen ik zelf en de rest krijg ik van jullie"*

			possibilities decisionmaking in living environment • Goede mogelijkheden tot inbreng van eigen zorg, dit is echter niet nodig Good possibilities decisionmaking in care	in dayplanning • Goede aandacht van de verzorging voor wat mogelijk is. *"Je bent niet alleen hier he, er zijn tweehonder vijftig mensen hier hoor, die moeten wel allemaal verzorgd worden hoor, en de een is nog zieker als de ander"* • Goede mogelijkheden voor bepalen van inrichten eigen kamer`, kinderen hebben het gedaan. • Good decisionmaking in living environment		
RESPECT	• Niet over gehad	• Goed contact familie	• Goed contact met familie	• Weet niet, maar dhr denkt dat het goed is	• Goed contact met familie	Unaniem goede contact met familie
EQUALITY	• Gevoel dat ze gelijk behandeld worden binnen de instelling Equal treatment/lack of interest	*"Ik denk dat ze allemaal zo'n zelfde zo'n beetje gelijk behandeld wordt. Maar als je zo zeurderig bent dan merk je wel dat ze, dan halen ze weleens adem.maar ze laten toch verder niets merken."* Equal treatment/ lack of	-*"Ja. Laatst ook weer toen reed ze hier en gaf ze rare brullen hoor ,maar dan zijn ze er wel bij, toen zeiden ze we nemen dr weer mee naar huis. En we geven dr wat dat ze een beetje rustiger wordt. "* • Mensen worden	• Heeft het idee dat iedereen gelijk behandeld wordt, geeft wel aan dat het allemaal aparte kamers zijn en dat hij daar eigenlijk niet zo'n zicht op heeft.	• Mevrouw moet meer betalen (voor bijvoorbeeld een nieuwe kraan) omdat ze er niet bij kan vanwege haar rolstoel • Unequal treatment based on	-

		knowledge	• verschillend • behandeld unequal treatment	• Equal treatment/lack of knowledge	wheelchair	
FAIRNESS	• Geen antwoord over fairness	• Mevrouw heeft geen klachten gehad, het is hier niet van toepassing. • No complaints		-weet niet waar hij terecht kan als hij kan klagen. Lack of knowledge	• Klachten over prikken insuline, nu is daar meer controle over. Mevrouw voelde zich serieus genomen. Complaint taken as priority • Klacht over het koude eten ingediend, er is niets veranderd Lack of interest in complaint	R3: Op een gegeven moment geklaagd omdat een intercom bij een andere bewoner nog aan staat, *"waar blijft dan je privacy?"* R3: het duurt lang om de badstoel te repareren. Dhr heeft geklaagd, na 5 maanden pas gerepareerd, voelde zich hier niet serieus genomen lack interest complaint R1: mevrouw heeft geklaagd over iets wat in haar zorgdossier stond, dit hebben ze gelijk veranderd. Priority complaint
	•	•			•	R5: Vind het vervelend dat er veel wisseling van het personeel is, je moet er steeds weer aan wennen. Personnel switch

Institution III

	Respondent 11	Respondent 12	Respondent 13	Respondent 14	Focus groep 4 personen
ACCESIBILITY					
Physical accesibility	-Goede fysieke toegangkelijkheid Physical accessible	• Goede fysieke toegangkelijkheid Physical accessible	-goede fysieke toegangkelijkheid in de instelling Physical accessible	Goede fysieke toegankelijkheid Physical accessible	R1: goede bereikbaarheid R3: met een rolstoel ook goed te bereiken Physical accessible
Economic accesibility	-redelijke prijs/kwaliteitsverhouding. Prijs wordt berekend naar aanleiding van AOW en pensioen. Value for money	• Weet niet, mevrouw houd wel geld over, zoon regelt dit. Rekeningen worden naar haar zoons huis toegestuurd Lack of interest	-dhr moet bijbetalen, maar is hier tevreden mee. Dochter regelt financien Value for money	Goede prijs/ kwaliteitsverhouding Kinderen helpen met financien Value for money/ dependence	R4: weinig ruimte om wat leuks te doen. Dependence
Information accesibility	-informatievoorziening is goed, dhr krijgt normaal altijd een krantje, daar staan alle gegevens van de hele maand in. -geen informatie gehad over rechten als patient Lack of information on patient rights	• Goede informatievoorziening : via een brief. • Geen informatie gehad over rechten als patient • Good information/ lack of knowledge on patient rights/lack of interest	-goede informatievoorziening -geen informatie over rechten als patient Good information/ lack information on rights	Goede informatievoorziening. Geen informatie over rechten als patient Good information/lack of information patientrights	Goed informatie activiteiten Geen informatie rechten Good information activities Information activities/ Lack information rights
Non-discrimination		• *"vandaar dat ik ook een eigen kamer heb, daar heeft de psychologe en familie voor gezorgd"* • Mevrouw heeft een 1 persoonskamer terwijl anderen in een tweepersoonskamer verblijven • Inequality	-gedeelde kamer, maar er zijn ook 1 persoonskamers Inequality		

QUALITY					
Quality services	• Weinig initiatief . De verzorging doen wel dingen, maar het is nooit volledig. Incompleteness careservices • Dhr ervaart hij altijd wat moet zeggen. • Komt zelf met suggesties met betrekking tot gezondheid bv: Heeft zelf voorgesteld omzuurstof 's nachts te hebben. Active role in own health • “ze zijn van goede wil, maar het zijn teveel amateurs en te weinig professionals” vakkundigheid van het personeel verschilt per persoon Lack of knowledge personnell/ lack of experience personnell	• Geen oordeel *"ze doen hun best"* • Heeft het idee dat de zusters goed op de hoogte zijn van haar gezondheidsklachten Collective feeling/ Acceptance/Good knowledge of health status	-“ze zorgen goed voor me hoor” -uitstekende kwaliteit zorg Good quality care	“meer dan hun best kunnen ze niet doen” Veel flexpoolers Zusters zijn goed op de hoogte van gezondheidsklachten Collective feeling/ Acceptance of quality of care / good knowledge on health status	R2: veel flexpoolers, hierdoor veel nieuwe gezichten, vaak moet je mensen vertellen hoe of wat. Switching personnell R1: mensen die minder ervaren zijn, zijn natuurlijk ook wat minder goed. Acceptance of quality of care/Dependent on person
Quality materials	• "Ik heb een electrische rolstoel maar die moeten ze nog in orde maken" Materiaal dient nog aangepast te worden. Lack of service	• Als de rolstoel mankementen heeft dan wordt het gelijk gemaakt. • Good service	-goede kwaliteit rolstoel Good service/good quality		Goede kwaliteit gebruikte materialen Good quality used material
AVAILABILITY	- Ze komen insulin spuiten en dan voor de krant pas anderhalf uur later Lack of effectiveness - Beschikbaarheid verschilt per medewerker Dependent on person - Personeel wisselt teveel Switches in personnell - Dhr kan ze altijd met de bel bereiken, vind wel dat ze een	• Lange wachttijd," *ze kunnen niet sneller reageren want er zijn veel mensen, het is geen onwil"* *Long waiting times/ acceptance of provided care* • Over het algemeen goede beschikbaarheid, maar er zitten ook minder goede dagen tussen. • Goede bereikbaarheid via de bel Good reachability	-in de avond is er tekort. Lack of personnel evening - Lang wachten. 20-30min Long waiting times - Wel ten alle tijden te bereiken middels de bel - Good reachability	-Ooit lang wachten, in principe bereikbaarheid goed Beschikbaarheid redelijk tot goed Long waiting times/ good availability/ good reachability /	R4: soms hebben ze het gewoon druk, dan moet je wat langer wachten. Acceptance of situation R2: ze doen hun best Collective feeling/not wanting to complain Soms langere wachttijden, tekort

	beetje laat reageren (15min) "want als er nou iemand een hartinfarct krijgt, of een hersenbloeding en je komt pas twintig minuten later, nou, dan zit diegene allang bij Petrus" - Long waiting time/ lack of reachability			acceptence	aan personeel mn 's avonds Sometimes long waiting times/ lack of personnell at night
ACCEPTABILITY					
Cultural	- Goede afstemming persoonlijke behoeften - Good acceptability	• Goede afstemming persoonlijke behoeften Good acceptability ,sensitive towards personal needs	-goede afstemming van behoeften Good acceptability	-goede afstemming persoonlijke behoeften Good acceptability/sensitive towards personal needs	- Goede afestemming - Good acceptability -
Belief	- Goede afstemming	• Mevrouw is doopsgezind Lack of possibilities in terms of belief	-geen geloof	- Goede afstemming op geloof	R1: ik maak geen gebruik van deze activiteiten want ik ben niet gelovig R3: goed afgestemd
Age	-goede afstemming op leeftijd	• Goede afstemming	-goede afstemming	- Goede afstemming op leeftijd	R4: ze houden goed rekening met je leeftijd. R1: sommige wat jongeren moeten het nog een beetje leren Lack of empathy
Medical Ethical	- Weet ik niet, zal wel goed zijn - Lack of interest/lack of	• Weet ik niet, zal wel goed zijn. Lack of interest/ lack of knowledge	-goede omgang vertrouwelijke informatie	Weet niet, ik denk het wel Lack of	R1: ik denk goed R2: hier niets over gehoord.

	knowledge		Good attitude towards medical ethics	interest/lack of knowledge	Lack of interest/lack of knowledge
DIGNITY					
Internal	*"bekijk dat dan niet als kritiek hoor"* *Not wanting to complain* -ik heb hier met mensen te doen, ik wil daar niet over mopperen.	• Mevrouw heeft het gevoel dat ze vast zit. Het zal nooit zo worden als thuis. Lack of home feeling/ acceptance of situation • Mevrouw vind het vervelend om afhankelijk te zijn Dependence	- Ik wil graag bij mijn vrouw zijn Home feeling	*"Ik wil niet zeuren"* *Not wanting to complain* Gevoel van eenzaamheid Mevrouw vindt het vervelend om afhankelijk te zijn. Dependence	Niet besproken
External	- Veel verschillende mensen die helpen. Dhr moet ze allemaal opnieuw instrueren. Lack of knowledge personnell health status - Goede bejegening personeel - Respect - Aandacht van het personeel verschilt heel erg per persoon - Sensitivity towards needs/depends per person	• Soms (bij sommige zusters) dan is geeft mevrouw aan dat ze anders benaderd zou willen worden. *"Zuster, u kunt het ook op een andere manier zeggen"* Feedback on communication with personnel • Mevrouw kan zich best voorstellen dat zusters 's soms ochtends chagerijnig zijn, want het is best vroeg. *"allemaal kunnen we reageren en allemaal op een verkeerde manier"* *Acceptance of situation* • Gezondheidsklachten worden serieus genomen Sensitivity towards health status • Over het algemeen goede bejegening • Goede persoonlijke aandacht van de verzorging Personal attention	- "Ze komen regelmatig bij je kijken." Personal attention - Voldoende persoonlijke aandacht - Goede bejegening Good communication	- Goede bejegening personeel - *"de een ligt je wat beter dan de ander"* Relationship dependent per person	
AUTONOMY	-Dhr bepaalt zijn eigen broodbeleg -Dhr kan kiezen over wat hij doet op een dag Good possibilities in decision making	• Weinig inbreng over tijdstippen verzorging, heeft dit echter nog nooit gedaan. Lack of decisionmaking care • Er zijn goede mogelijkheden om haar dag	-Geen mogelijkheid om te kiezen met zijn vrouw een kamer te delen (dhr zijn vrouw	Eigen kamer ingericht met behulp van familie Voldoende	R3: zelf de dag inplannen is goed mogelijk R4: iK heb mijn eigen

	dayshedule - Zoon heeft appartement van dhr ingericht Lack of interest in decision making living environment	zelf in te delen en zinvol in te vullen. Good possibilities in decision making day shedule • Mevrouw eet liever 's avonds warm, heeft geen mogelijkheden om dit te kiezen, maar dit gaat in de toekomst veranderd worden. • Goede mogelijkheden om zelf de kamer in te richten. Good possibilities in decision making living environment	woont op dezelfde afdeling) Lack of possibility decision making living environment/home feeling -voldoende mogelijkheden om eigen dag in te plannen Decisionmaking possibilities dayshedulde	mogelijkheden om zelf de dag zinvol in te vullen Decision making dayshedule / decision making living environment	kamer kunnen inrichten. Decision making dayshedule / decision making living environment
RESPECT	-goede omgang met familie	• Goede contact met de familie	-goede omgang met familie	Goede omgang met familie	Unaniem: goede omgang met familie
EQUALITY	- Weet niet Lack of knowledge	• *"vandaar dat ik ook een eigen kamer heb, daar heeft de psychologe en familie voor gezorgd"* • Mevrouw heeft een 1 persoonskamer terwijl anderen in een tweepersoonskamer verblijven, had eerst een tweepersoon kamer • Heeft het gevoel dat iedereen gelijk behandeld worden. Inequality/ feeling of equality	-denkt dat het wel gelijk is. Lack of knowledge/ lack of interest	Weet niet, verzorging komt bij anderen op de kamer, ziet mevrouw niets van Lack of knowledge	Unaniem: denken dat iedereen in principe gelijk behandeld wordt
FAIRNESS	- Dhr heeft klachten over de was. Ze zullen onderzoeken. - Twee keer geklaagd maar daar is niet zoveel mee gedaan, dhr heeft wel het gevoel dat hij serieus is genomen - Lack of action complaint	• Kan terecht bij haar evver als ze een klacht heeft ervaart dit als heel fijn. Heeft hier geen gebruik van gemaakt.		-geen klachten gehad, heeft een contact persoon om de dingen te bespreken	Niet besproken ivm tijdgebrek
Optional	• Ervaart dat ze het economisch niet goed bekijken, bv: flessen zuurstof zijn duurder als een	• Mevrouw geeft aan dat ze ervaart dat vanuit de sommiger bewoners naar jonge verzorgsters toe handtastelijk zijn, ervaart dit	-dhr is van geld bestolen Lack of safety		

	kastje zuurstof. Lack of economic effecienty	als zeer onprettig Sexual intimidation young female personnel	- "sommige dingen zeg ik niet om narigheid te voorkomen" Fear/ not wanting to complain - "hou het onder ons alsjeblieft, niet dat het hier bekend wordt" - Dhr is geslagen door zijn kamergenoot - Lack of safety		

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