Work-related change in residential elderly care: Trust, space and connectedness

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Abstract
Increasing care needs and a declining workforce put pressure on the quality and continuity of long-term elderly care. The need to attract and retain a solid workforce is increasingly acknowledged. This study reports about a change initiative that aimed to improve the quality of care and working life in residential elderly care. The research focus is on understanding the process of workforce change and development, by retrospectively exploring the experiences of care professionals. A responsive evaluation was conducted at a nursing home department in the Netherlands one year after participating in the change program. Data were gathered by participant observations, interviews and a focus and dialogue group. A thematic analysis was conducted. Care professionals reported changes in workplace climate and interpersonal interactions. We identified trust, space and connectedness as important concepts to understand

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perceived change. Findings suggest that the interplay between trust and space fostered interpersonal connectedness. Connectedness improved the quality of relationships, contributing to the well-being of the workforce. We consider the nature and contradictions within the process of change, and discuss how gained insights help to improve quality of working life in residential elderly care and how this may reflect in the quality of care provision.

Keywords
authenticity, autonomy, case study, connectedness, leadership, quality of care, quality of working life, responsive evaluation, trust

Introduction
Western societies are ageing, and health care needs are increasing (Rijksinstituut voor Volksgezondheid en Milieu, 2013; Ursum et al., 2011; World Health Organization, 2014). At the same time, the workforce population is declining (Raad voor de Volksgezondheid en Zorg, 2012). To ensure continuity and quality of long-term care for older people, there is a need to develop new care practices that contribute to the well-being of both care receivers and care providers. Better understanding of the process of workforce development may help to improve quality of working life in elderly care and help to attract and retain a solid workforce.

Residential elderly care: State and strains
In general, elderly care is characterized as a ‘low pay and low status sector’ (Simonazzi, 2009: 220), dominated by hierarchy, rules and (cost) efficiency. Underpaid and undervalued labor is mainly performed by less educated women in part-time employment and increasingly depends on migrant workers (Simonazzi, 2009). Nevertheless, care workers do often feel rewarded and fulfilled by the perceived meaningfulness of caring for others and their emotional attachment with residents (Ball et al., 2009), although social interaction with residents is under pressure by increasing rationalization and depersonalization of care. More and more, the (mainly female) workforce has become part of a Tayloristic system in which strong task division, standardization and regulation mechanisms dominate daily conduct. Care needs are converted into calculated operations, and staff are often framed as an instrumental source, expressed in terms of costs and quantities. Care workers are exposed to unfavorable working conditions, such as heavy workloads, high time pressure, and strong physical and emotional demands (Douwes et al., 2008; Peeters et al., 2008). The work is often routinized and characterized by low decision authority and task control (Saarnio et al., 2012). These burdensome conditions and work characteristics are not without consequences.

According to the Job-Demand-Control model (Karasek and Theorell, 1990), a lack of autonomy is an important determinant of work stress, especially when job demands and time pressure are high (Karasek and Theorell, 1990; Karasek et al., 1998). Although the majority of the care workers work part-time, the time to recover from physical and mental
strain is often too short. Structures and mechanisms established to guarantee efficiency and quality of care often put extra demands on the workforce and negatively impact employee outcomes. Despite feeling intrinsically motivated, many run the risk of feeling overburdened and, in combination with low wages and low job status, their feelings of disrespect and under-recognition provoke health-related absenteeism, turnover and job dissatisfaction (Merens and Van den Brakel, 2014; Sonnentag and Zijlstra, 2006).

Consequently, these negative employee outcomes affect the quality of the delivered care. High turnover is costly, interrupts the continuity of care, and is associated with lower patient-care outcomes (Eaton, 2000). Work and care systems are thus mutually linked, but concurrently optimizing both seems to be challenging.

**Need for research and new perspectives**

In current debates on the sustainability of long-term elderly care, the ultimate (and seemingly incompatible) aim is to develop care practices that contribute to the well-being of both care receivers and care providers, while at the same time serving organizational objectives. This aim is even more challenging in times of increasing care demands and less available resources. With regard to the well-being of the workforce, the field of organizational behavior and HRM practice emphasize the importance of job quality (Findlay et al., 2013; Holman, 2013), preventive measures and remediating workplace stress (Karasek, 1979; Karasek and Theorell, 1990). Therefore, much attention is paid to fostering job satisfaction and work motivation. The Job Characteristics model (Hackman and Oldham, 1980) identifies various job features that tend to make a job satisfying and intrinsically motivating (such as task variety, autonomy and decision authority). Work engagement has also been identified as an affective-motivational state and an important indicator of occupational well-being (Bakker et al., 2008).

In light of the current paradigm shift towards a more humanistic approach of care (Chapin, 2010; Raad voor de Volksgezondheid en Zorg, 2012; Van Campen, 2011), quality of care is increasingly sought in tailoring services to individual care needs (person-centered care) (Snoeren et al., 2016a) and user involvement (Abma and Baur, 2015; Baur et al., 2013; Boelsma et al., 2014). Awareness has raised that high-quality services strongly depend upon the care workers and their commitment and well-being, and that, especially in light of today’s economic challenges, human resources are pivotal (Luthans and Youssef, 2004). Questions arise as to whether and how alternative HRM practices and organizing care work may improve both the quality of working life and the quality of care (Eaton, 2000). Emerging local initiatives are not always reported in the literature, but some best practice examples exist – for instance, the ‘care innovation centers’ in the Netherlands (Snoeren et al., 2016a, b). These centers start from the assumption that workplace learning is essential for care workers’ flourishing, and that learning is inherently relational. Snoeren et al. (2016b) recommend promoting sustainable learning of employees – for example, via mentoring relationships. Yet another successful innovation, that has been replicated worldwide, is the home care ‘Buurtzorg model’ (De Blok, 2011). This is a nurse-led organization of self-managed teams that provide home care to patients. Autonomous teams work in the community and collaborate with primary care providers, community support and family members to provide patients the best optimal care. Gains
that have been attributed to this model are effective and efficient care, satisfied patients, and enthusiastic nurses (De Blok, 2011; Kreitzer et al., 2015; Nandram and Koster, 2014). Although these studies report on successful strategies and positive outcomes, the underlying process of workforce development has not yet been thoroughly examined. In this article, we report on an evaluation study of a change program entitled ‘From armor to summer dress’ that aimed to improve both the quality of working life and the quality of care in residential elderly care in the Netherlands. We examine the perceptions of change from a care worker’s perspective to gain in-depth understanding of the process of workforce development and improving the quality of working life. We reflect on the nature and contradictions in the process of change and discuss implications for the quality of care.

Method

Design

In this study (January to December 2012), we combined a responsive evaluation approach with a case study design. Responsive evaluations focus on exploring and exchanging different stakeholder perspectives (Abma, 2005, 2007; Abma and Widdershoven, 2005). In a responsive research approach, phases of data collection and data analyses partially overlap. By this iterative process, preliminary findings can be validated and further enriched throughout the research process. The responsive evaluation was carried out in three residential homes, and each home was approached as a case – a demarcated entity with its own culture (Abma and Stake, 2001, 2014; Stake, 1994, 2004).

In this article, we present the findings derived from one particular case. The main criterion to select this case was its learning potential (Abma and Stake, 2001, 2014). Compared with the other cases, we found this case example outstanding in revealing its complexity and social dynamics, creating a good understanding of activities and relationships (Abma and Stake, 2014). The evaluation was conducted by a team of four researchers, of which two have a background in care ethics, and two a background in work psychology.

Sampling and recruitment

We aimed to include a maximum variety of stakeholders in order to capture a broad range of experiences and perspectives. Stakeholders included members of board and management, care staff, an internal coach, a general practitioner and a resident. The ward manager was involved in recruiting staff and other stakeholders. The main criteria for selection were that participants had been involved in the program and were able and willing to share their individual experiences. We aimed to select staff at various job levels (e.g. nursing aide, nurse, supervising nurse) in order to gather a wide range of experiences and perspectives within the group.

Data collection

Over a period of eight months, two researchers (WB, LD) collected the data. First, four key persons who had been involved in the program and/or held managerial positions
participated in a semi-structured interview. By these interviews we intended to acquire insights into the perception of the individuals’ roles and responsibilities, to identify key issues, and to reflect on perceived changes. Also, expectations and attitudes toward the evaluation study were discussed. Subsequently, five semi-structured individual interviews were held with care staff. The interviews were guided by a pre-defined topic list. The main goals were to explore individual attitudes toward the program, personal experiences and perceived changes in the ward. One resident participated and discussed life at the ward (in general), her experiences with the program, and the perceived changes regarding the quality of care.

The researchers completed two participant observations to learn more about the day-to-day activities and the interpersonal interactions and to get an overall impression of the workplace atmosphere. Various staff members were informally interviewed, and brief conversations were held with some of the residents. The researchers took detailed field notes.

When no new themes/issues emerged from the interviews and informal conversations, data saturation was reached (Barbour, 2001; Mays, 2000) and the number of interviews were judged sufficient. Subsequently, three care workers participated in a homogeneous focus group to discuss themes that emerged from the interviews and observations. The moderator (WB) verified whether important themes were missing. In the final phase of data collection, we conducted a heterogeneous group discussion in order to facilitate dialogue between care professionals. Four care workers and the ward manager participated. The aim of this session was to develop a sense of mutual understanding by inviting participants to share their (differing) perspectives on both the positive and negative experiences within the program, and to reflect on the perceived changes in daily practice. Two researchers were present during the dialogue group – one of them moderating the discussion and the other monitoring the process and taking notes. All interviews and group discussions were tape-recorded, and fully transcribed verbatim.

We reviewed and analyzed several relevant organization and program documents to gain better understanding of the organizational context and to provide complementary information on program activities. Table 1 presents an overview of the research activities, participants and topics.

Data analysis

Data were subject to a thematic analysis (Braun and Clarke, 2006; Green and Thorogood, 2014). Two researchers screened the research material in detail, and categorized and coded themes that recurred from the data. Analyzed data included interview and group discussion transcripts, written reports, field notes of participant observations and organizational documents. The research team discussed emerging themes throughout the research process. Data collection and analysis were not guided by a predefined theoretical framework, but occurring themes were linked to theories of social and work psychology. We used these theories in a secondary analysis to further expand upon emerged concepts and to gain a deeper understanding of underlying mechanisms.
| Period (2012) | Phase | Activity | RP | Job position | M/F | Topics/focus |
|--------------|-------|----------|----|--------------|-----|-------------|
| Feb–May      | Deepening: Consultations on experiences | Participant observations | P5, P6, P7, P8, P9, P10 | Nurse aide, Nurse, Nurse aide, Supervising nurse, General practitioner, Resident | F, P, F, F, F | Exploration of individual perspectives and attitudes with regard to the program and personal experiences; gain insight into perceived changes in the ward with regard to work and interaction with colleagues and residents |
| June–Aug    | Integration: Evaluation of experiences | Dialogue group (n = 5) | P3, P11, P12, P13, P14, P15, P16 | Ward manager, Supervising nurse, Nurse, Nurse, Nurse aide, Nurse aide | M, F, F, F, F, F | Dialogue between various care professionals, share (differing) perspectives on both positive and negative program experiences, develop sense of mutual understanding, and reflect on perceived changes in daily practice |
|             |       | Document analysis | P1, P2, P3, P4 | Internal coach, Ward manager, Location manager, Director | F, M | Organizational registrations: turnover and sickness rates, job satisfaction, productivity |
|             |       | Document analysis | P1, P2, P3, P4 | Internal coach, Ward manager, Location manager, Director | F, M | Organizational registrations: turnover and sickness rates, job satisfaction, productivity |

RP = research participant; M = male; F = female. *P3 and P4 participated in a duo-interview.
Quality procedures

In order to ensure quality and to enhance the credibility of our study, we followed several quality procedures. Triangulation was achieved by applying various data collection methods (Mays and Pope, 2000). Using multiple methods helped us to enrich data and to gain a deeper understanding of emerging themes. Written interview reports were sent back to the interviewees and to focus group participants in order to validate findings and to improve credibility (Lincoln and Guba, 1985; Mays and Pope, 2000). The researchers who collected the data analyzed the research material independently and compared their findings. The research team met on a regular base to discuss preliminary findings. Reflections within the team helped to prevent personal bias in the data interpretation. The team discussed differing interpretations until they reached consensus, and described the study’s context in detail to foster naturalistic generalization (Abma and Stake, 2001, 2014).

Case example

From armor to summer dress: Background, program and setting

In 2007, the Dutch government raised a national transition fund to give an innovative boost to long-term care. The thought behind this initiative was that only radical innovations may counteract the growing complexity of care systems and erosion of quality and adequacy of delivered care. Grounded in the idea that care organizations and professionals themselves can best sense deficiencies and needs from their everyday expertise, a call was opened for submission of project proposals addressing ‘outside of the box’ solutions for everyday constraints. The fund supported in total 26 various local experiments targeted at innovation in culture, structure and work procedures. It was reasoned that by broadly sharing experiences and findings from these small-scale experiments, the whole sector could profit from gained best practices and insights (Ministerie van Volksgezondheid, Welzijn en Sport, 2009).

A director of an elderly care facility, a health care labor market knowledge center, and a consulting company jointly envisioned innovation in long-term elderly care and developed the change program ‘From armor to summer dress’. They signaled the need to counteract the adverse effects of deeply ingrained patterns and structures (armor) in elderly care, which gradually impoverished the quality of working life and the quality of care. According to the founders, the loss of interpersonal connections should be seen as one of the main barriers to providing good care in a pleasant and workable manner, and therefore stressed the importance of relational quality. Based on the fundamental idea that satisfied and compassionate care workers are essential in the provision of sustainable and high-quality care, the program emphasized the importance of acknowledging and stimulating individual talents and personal motivations. The program prescribed a set of general aims, mainly focusing on care workers and their work context, which were: talent development, increasing autonomy (by facilitating leadership) and optimizing work processes.

Unlike the implementation of an evidence-based intervention, the program philosophy was grounded in the idea that an intervention should be context-based,
connecting and responding to contextual factors and involved actors. Therefore, the program was not designed according to a fixed protocol to be implemented within care organizations following standardized methods. The founders strongly advocated a customized and practice-based approach in collaborative action with involved stakeholders.

When the proposal was granted, four Dutch elderly care institutions were selected to participate in the program. Conditions to participate were identification with the program philosophy, organizational commitment and capacity, and absence of organizational disruptions such as reorganizations. Each of the participating care organizations was free to customize their own intervention methods, as long as activities were in line with the overall program philosophy and general aims, and based on the needs and desires of involved stakeholders (care workers and residents). Team leaders and managers were assigned a key role in facilitating employees and were therefore trained to adapt to a coaching leadership style.

One of the funding requirements was to give insight in both economic and societal costs and revenues of the proposed experiment. Therefore, a set of quantifiable output measures were determined to assess effects and gains of the program. Targets were to reduce sickness absenteeism and turnover rates, and to increase job satisfaction, productivity and quality of care. An external research company evaluated the program at each of the four participating institutions following a quasi-experimental design, but no significant effects could be measured on the determined output variables (Klein Hesselink et al., 2011). Whereas in-depth interviews with stakeholders pointed out that various favorable developments were perceived at face value, it was recommended to perform a subsequent qualitative evaluation, to adequately analyze and interpret this perceived change (Klein Hesselink et al., 2011). The VU University Medical Center was commissioned to conduct this qualitative study. A case study design and responsive evaluation approach were chosen as research methods to best fit and complement the program philosophy.

This study was conducted at the somatic care department of one of the participating nursing homes. The department provides small-scale care at eight separate homes, each housing eight persons. The residents are older people with physical disabilities and sometimes cognitive limitations. The majority of the residents are wheelchair-dependent. Each resident has a private bedroom with a toilet, and each home has a communal living room with a TV corner, a kitchen and a large dining table. A team of five to 10 care workers is assigned to each of the homes.

The functional levels of care staff differ as follows: nursing aides provide basic personal care to residents and perform household tasks; nurses are qualified to administer medications and perform medical procedures; and the supervising nurse, who supervises the nursing staff, manages daily issues and serves as a contact person for relatives. The supervising nurse also carries out the documentation and reporting of activities. A ward manager holds responsibility for the overall management of the eight homes and reports to the location manager. In March 2010, the department was offered the opportunity to participate in the experimental change program. Four homes were included in the program, involving 32 residents and 28 care workers (four supervising nurses, 13 nurses, and 11 nurse aides).
**Phase 1: Manifestations of the armor**

At the start of the program the work situation was metaphorically characterized by ‘armor-like’ conditions, which induced a need for change.

**Heavy workload and strong task orientation**

In 2009, the nursing department had moved into a new building designed for small-scale care, offering home-like facilities. It was expected that this new home-like work environment would provide ground for closer interaction between care staff and residents and better patient-centered care. However, it turned out that rigid working routines were hard to break and that a strong task orientation remained dominant. Care workers even perceived an increased work load and higher job demands since they were assigned to perform additional household tasks, such as cooking, cleaning, laundry and ironing. Care workers also stated that they still perceived a lack of (quality) time to spend with the residents. The residents perceived their contact with staff as task-oriented and rushed.

Board and management saw the change program as a welcome opportunity to better shape the way of providing care in a home-like setting. Although some care workers expected the program to be time-consuming and demanding, others were hopeful: ‘I thought ‘yes, now we are being heard, they finally understand! We are getting help and we are understood, at last!’”.

**Lack of collaboration**

According to different stakeholders, the work situation was characterized by a lack of collaboration between teams. The homes operated as separate subsections, and assisting colleagues at other homes was uncommon. The lack of collaboration resulted in poor knowledge and information-sharing. According to the general practitioner, care workers were sometimes not informed about critical situations at other units. For example, one resident was terminally ill without team members of the neighboring units knowing about it. When, for various reasons, the staff rotation between the teams became inevitable, it was difficult to adapt. A nurse aide recalled: ‘We were told to help out at the other care units. First we were not allowed to help, and then we had to. In the beginning it was very difficult to make this shift’.

The ward manager stated that the change program offered a good opportunity to explore how to improve team collaboration and to foster pro-social work behavior within and between the teams: ‘We wanted to create group cohesion, foster cooperation within and between the teams. Just to make everybody realize that we are one department instead of four independent subunits’.

**Tight leadership**

The ward manager’s leadership style was characterized by a directing and controlling attitude towards the staff. Care workers were provided with clearly defined tasks and
were not expected to take responsibility and solve work-related problems themselves. They were not involved in decision-making and hardly encouraged to take initiatives. The ward manager described his management style as follows:

… by firmly holding on to procedures and being very directive, telling them: ‘This is the way we do it.’ And I made myself problem owner of all kinds of issues. I created a ‘high fence’ and let everybody just drop all kinds of matters that I could solve and work on.

The ward manager was under strain by continuously striving to be in control and felt that interaction with staff was not very productive or satisfactory. Therefore, he felt the urge to change his leadership style.

**Concluding thoughts on phase 1**

In many ways, the organization and the persons involved were affected by the armors’ oppressive and rigid nature. The need for change was widely acknowledged. The main question was how to transform the existing harnessed conditions into a more client-centered culture and an engaging work environment.

**Phase 2: Untightening the iron grip**

The program facilitated change in various ways. Instead of implementing a standardized intervention, all involved stakeholders were meant to have a say in the program development. See Table 2 for a description and objectives of activities that were initiated at the ward. Critical events are described below.

**New perspectives on leadership**

Owing to his former position as a specialized nurse at the top clinical level in an academic hospital, the ward manager was used to fairly high standards of care quality. By individual training on facilitating leadership, provided by an external facilitator, he became aware that these expectations formed the main barrier in his interaction with the staff. Discussing situations from everyday practice and reflecting on behavior and thoughts about his managing role facilitated his adapting to a more supportive leadership style. He started to acknowledge the value of a more collaborative relationship with the team members, and to pay attention to individual talents, strengths and learning potential. Whereas his main focus used to be how to stay in control and how to get staff to follow instructions, he learned to shift his focus towards how to facilitate each individual staff member and to provide all of the necessary resources to enable them to deliver high-quality care. He recalled his challenge, saying:

The main challenge is in questioning: ‘What does this employee need to do his or her job in such a way, that we can all be proud of what we do and provide high-quality care’ … To me, this was an important mind shift.
| Activity                     | Description and objectives                                                                                                                                                                                                 |
|------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Interviews                   | Interviews with care workers and residents to identify needs, wishes and expectations of the program. Objectives: Create commitment, recognize needs, establish ownership                                                                 |
| Team inspiration sessions    | Inspirational team sessions guided by an external coach. Explore individual and team talents and brainstorm about how to improve collaboration, work procedures and client-centered care. Objectives: Create awareness of individual and team talents, team-building, and develop problem-solving abilities (Coaching based on theories of positive inquiry [Cooperrider and Whitney, 2005]) |
| Home meetings                | Home meetings to discuss daily matters and issues. Residents, care workers and other stakeholders participate. Objectives: Client inclusion and shared decision-making, encourage care workers to start dialogues with the residents, and develop responsiveness to residents’ needs |
| Think-tank                   | Thematic work groups in which care workers collaborate across teams (themes e.g. cooking, decoration and outdoor activities). Objectives: Reinforce individual and workgroup initiatives, develop talents, increase sense of ownership, encourage shared responsibility, foster collaboration and interpersonal bonding, and improve the care quality |
| Team reflection sessions     | Team sessions guided by an external coach. Reflection on care practices, and on personal and others’ work behavior, and training on feedback skills. (Coaching based on theories of positive inquiry) Objectives: Improve feedback skills, mutual understanding and collaboration, and develop reflexivity |
| Individual coaching          | Reflect on personal and professional roles, discuss work-related issues, and explore personal strengths and competencies. (Coaching based on theories of positive inquiry) Objectives: Strengthen self-confidence/self-efficacy, encourage pro-activity, develop reflexivity |
| Workshop ‘Dress for success’ | Workshop focusing on interpersonal interactions, communication, and non-verbal behavior and self-presentation. Objectives: Create self-awareness, gain insights into the effects of communication and non-verbal behavior, and encourage open attitudes |
| Workshop ‘Reversed’          | 24-hour workshop in which care workers experienced a care-receiving role. Objectives: Develop capacities to empathize with residents, improve client-centered attitudes and behavior, and develop reflexivity regarding daily care practices |
| Training assertiveness       | Workshop guided by external coach. Effective communication and conflict management. Objectives: Empowerment, setting limits and recognizing personal boundaries |
**Personal development and professional growth**

Throughout the project, employees were invited to request personal coaching to address work-related issues and concerns. The coach who was assigned to this role was already employed by the care organization as an in-company trainer on personal growth and development. She was asked to participate as a member of the project team to facilitate the change program. She led group activities and was available for individual consultation. The coach recalled that care workers were reluctant to request individual consultation at first, but as they met on a regular base and had informal conversations, trust slowly developed. Many care workers seemed to struggle with low self-confidence. They often felt alone and insecure about being responsible for all of the residents at their home. The coach recalled the situation, saying: ‘It became very clear that some people felt quite insecure when working alone at a care home. And these insecurities could take serious forms’.

Also, dilemmas arose with regard to personal and professional roles in interaction with colleagues and residents. By evaluating the work situations and experiences, the coach aimed to create awareness about individual talents and competencies, to promote a sense of self-confidence and to help care workers strengthen their caring roles. Her coaching style was based on the positive inquiry approach, which is grounded in the search for positive experience, is appreciating and valuing, and directed at developing (individual) strengths (Cooperrider and Whitney, 2005).

**Openness and bonding**

Group sessions and team-building events encouraged the staff to interact and to get to know each other on a deeper level. By stimulating reflectivity about their own and others’ personal vulnerabilities, these sessions facilitated bonding and encouraged participants to open up to each other. For example, one of the nurses reported about a workshop that focused on creating awareness of non-verbal behavior and communication. One aspect entailed personal clothing and make-up advice and required participants to remove their facial make-up. She recalled that for her it was a huge barrier to take off her make-up in front of her colleagues, and she resisted. However, when being open about her personal barriers, she felt acknowledged and understood. Eventually, the positive and joyful atmosphere within the group promoted a feeling of security and encouraged her to give in. She said:

And for me, it was a big thing, but I did it. And now I’m like, ‘Yeah, gee, I dared just to be myself’ … We just felt [that] … everyone … everyone was like, ‘Who cares? We know each other’ … Yes, feeling familiar with each other.

**Dialogue and responsiveness**

To develop the care workers’ capacities to empathize with residents, the department hired an external agency to organize a 24-hour workshop in which the care workers
could experience a care-receiving role. The care workers affirmed that they gained valuable insights by experiencing a sense of dependency and feeling restricted in making personal decisions. This raised awareness about the importance of clear communication with residents. One care worker explained that when residents called, she used to tell them, ‘I’ll be there soon’. But the training helped her to realize that ‘soon’ is a broad and vague concept for someone who is thirsty or needs to go to the toilet. She reported: ‘Now, when they [residents] call, I’m more aware of this. Now I always try to be clear about timings, and indicate that it will take me another three minutes, for example’.

Yet, being more aware of residents’ needs also increased a sense of distress. A nurse explained that the workshop made her experience how it feels for a wheelchair-bound resident to depend on care staff just to visit the toilet: ‘Now that I know how it feels, it feels even worse. I really struggled with that emotion. It gave me the feeling that we just can’t do it right’.

To encourage resident participation and dialogue, home meetings were initiated for residents, care workers and other stakeholders. During these meetings, residents were invited to share their opinions about daily matters in the home. Although it did not succeed at all homes, the coach remembered various occasions in which a meaningful conversation got started. One, for example, began with a resident complaining about the food. The coach recalled:

[A resident] clearly stated: ‘I don’t like the food at all’. In reply, one of the care workers asked for clarification. The resident continued by stating that the vegetables were not well prepared at all. Then one of the care workers asked, ‘How could this be improved?’ [Then] the conversation got started. Different issues were raised, not only about the food, but also about agreements and privacy matters.

**Challenges and bottlenecks**

Overall, care workers had mixed feelings about how the project proceeded. The many project activities put extra pressure on daily work, and an obligation to participate at unscheduled work hours even impacted their spare time. Thinking back to the announcement of the 24-hour workshop, a nurse recalled: ‘We were all just shocked that we had to be present for 24 hours’. Care workers also complained about a lack of backfill, contrary to promises of the project team.

The high workshop costs made the project team decide to oblige care workers to participate. The ward manager explained that this felt like an awkward decision as ‘obligation’ was not in line with the project philosophy: ‘You just want commitment, you just want people to participate. You want them to enjoy it and that they get inspired’.

When resistance grew even stronger, the project team decided to talk to each care worker individually, in order to find out where resistance came from and what they could do to overcome. In the end, many of the practical problems could be solved and the majority of staff participated in the workshop.
In general, care workers initially perceived the project as ‘fixed’ and did not feel they had much to say about the course of action. A nurse aid expressed the sentiment: ‘At some point, we called it ‘From summer dress to armor’. The ward manager regretted that they did not succeed in creating more ownership and engagement among staff. He indicated that problems within the project team also impacted this process. Although each individual project member embraced the ‘summer dress’ ideology, at the start the team had faced disagreements and internal disputes about how to interpret this philosophy and how to implement it. He noted:

That was a serious point of discussion – to what extent can you push people to participate outside working hours in a project that renders to create more space and to improve collaboration and better communication? This was at odds with each other.

Care workers also expressed that it was unclear why they were appointed to participate in the change program. Two care workers recalled:

It felt as if we did not do a good job, because we were the ones who had to change. That was the feeling it gave me. Why only us – and not the care home as a whole? –Yes, we all wondered ‘why us?’.

Concluding thoughts on phase 2

Untightening the iron grip turned out to be a demanding and ambivalent process. In addition to its counterproductive impact, the armor also functioned as a protective shield, offering security and safety, to some extent. Questioning one’s own and others’ working practices and debating about care quality came with feelings of vulnerability and insecurity. Reallocating roles and responsibilities required reflectivity and new perspectives on social exchange and relational dynamics. This put pressure on and required efforts of all involved.

Phase 3: The summer dress within reach: Lithe but fragile

More than one year after the completion of the project, the stakeholders perceived a change. Below, we describe several aspects of this transformation and how it affected their interpersonal interactions.

Workplace atmosphere

The workplace atmosphere was perceived as more open. Care workers got to know each other better, and this contributed to the improvement of personal contact and mutual understanding. Some care workers noted that the team spirit had become stronger, positively affecting the work-floor interaction. According to a nurse aide, work-related issues were addressed more easily during team meetings, and care workers were more comfortable, such as by sharing differing opinions. She said: ‘In the past, it wasn’t like this … We just have become more open towards each other … We have become a closer team’.
She added that, compared with how it used to be, appreciation for what goes well is also more commonly expressed. Employees spoke up more often and reminded each other about responsibilities if agreements were not met. The coach also observed that the staff felt safer expressing feelings and opinions and providing each other with feedback. A majority of the care workers considered feedback valuable for the workplace atmosphere. However, most of them still found it difficult. Additionally, pressing work schedules did not always allow them to take time for feedback. Some mentioned that maintaining and improving feedback skills needs continuous attention and training.

**Collaboration**

Different stakeholders reported that collaboration between the teams had improved. Although staff members were used to focusing on ‘their own’ home, providing help to colleagues at other units became more common. A nurse aide, for example, said: ‘Now, when I have finished work here, or when I know one of my colleagues needs support, I just go there to offer help’. If support was not offered, asking for help was more usual. Initiated by care staff, structural work meetings were implemented. At this one-year follow-up point, four times a day, staff members from the four homes (one delegate each shift) were gathering to brief each other about the status of care and important matters. The general practitioner noticed that sharing information had become more structural, saying: ‘This is something that has changed. It feels good to know that they now support each other and that everybody is up to date about important matters. It also makes it easier to hand things over to each other’.

Care workers acknowledged that being better informed reduces feelings of distress and insecurity and fosters a supportive attitude. One of the nurses stated: ‘Being informed about the situation at other homes makes it more easy to say, “I dare to go over there to do the work”, because I know them [the residents]’.

According to the ward manager, the number of complaints about poor cooperation decreased and he was more often informed about what was going well.

**Taking initiatives and solving problems**

According to the ward manager, staff members had become more aware of their overall shared responsibility and took more initiative to solve work-related problems themselves. For example, he said:

Now it happens more often that a staff member contacts me to say: ‘colleague x called in sick today, but I have already called colleague y and she will take over tonight’s shift’. They can’t make me happier. Before, they only used to report ‘colleague “x” called in sick today’.

The coach noticed several employees applying their gained experience in daily practice. For example, one of the supervising nurses had recently initiated a team
meeting to discuss how to further improve collaboration and how to divide tasks and responsibilities according to individual qualities and interests. As a result, one of the staff members who was personally interested in cooking became in charge of the kitchen, groceries and alignment with residents about their meal preferences. Yet another team member was acknowledged for her creativity and given the opportunity to organize creative events such as floral art sessions with residents. As the coach concluded: ‘She [supervising nurse] really addressed the personal talents of people’.

Facilitating leadership

The ward manager stated that he had become more supportive and that, instead of giving orders, he focused on posing questions (such as, ‘How do you think about this problem yourself?’). One of the staff members recalled a situation in which she reported a problem to her manager. To her surprise, he responded by asking how she would solve the problem herself. She remembered having ambivalent feelings when he did this. On the one hand, she informed him to just let him solve the problem; she did not intend to find a solution herself. On the other hand, she felt it was good, because it made her think about the problem herself.

The ward manager also noted that by creating a shared responsibility for resolving problems and decision-making, care workers felt taken seriously, and were gaining more self-confidence: ‘They become more independent and feel that trust is stated in them’.

He believed his shift in leadership style affected his connection with the staff members and also mentioned that mutual trust was an important condition for establishing this ‘more collaborative’ relationship.

Concluding thoughts on phase 3

As various stakeholders clearly defined the perceived change, the conclusion could be drawn that a meaningful transformation took place. Nevertheless, newly developed (social) constructions were still frail and needed further maturation.

Case analysis

In this section, we further analyze the case study by taking a closer look into the process of change. We identified trust, space and connectedness as important concepts with regard to interpersonal relationships between care workers, and between care workers and their manager. See Table 3 for a concise overview of the change process.

Trust

We identified trust as one of the key concepts in the case, taking various forms throughout the process of change. Trust is widely acknowledged as an important factor in (work) relationships and has been defined as ‘a psychological state comprising the intention to
### Table 3. Overview: Trust, space and connectedness.

| Phase 1: Manifestations of the armor | Lack of trust, space and connectedness |
|-------------------------------------|----------------------------------------|
| Organization characterized by financial cutbacks, protocol and checklist thinking, strict procedures, administrative demands, and strong task orientation | Accountability systems promote an overall climate of distrust |
| The ward manager maintains a transactional leadership style and a control-based interaction with staff | Stakeholders prevented from connecting |
| No staff involvement in decision-making; the manager is the problem-solver | Employees are restricted in decision latitude; job autonomy is low |
| Care staff are under pressure of high workloads, time pressure, and strong task division, resulting in a lack of collaboration and feelings of isolation | Manager states low trust in capabilities of employees |
| | Workforce is deployed as an instrumental source, suppressing individuals’ authenticity |
| | The contractual relationship indicates a weak connection between the manger and care staff |
| | The lack of interaction inhibits exchange, trust development, and personal bonding, indicating a lack of connectedness among staff members |

| Phase 2: Untightening the iron grip | Facilitating development of trust, space and connectedness |
|-------------------------------------|----------------------------------------------------------|
| The ward manager gains insight into the effects of control-based leadership and develops a transformational leadership style | The ward manager learns to release control and to trust staff |
| The ward manager involves staff in decision-making, starts to recognize individual strengths and encourages personal development | The ward manager involves staff in decision-making, starts to recognize individual strengths and encourages personal development |
| Staff members participate in team building and collective program activities. They initiate structural team meetings in the ward | Psychological safety is fostered, promoting a sense of openness |
| | Social interaction and knowledge exchange encourage trust development and interpersonal bonding |
| Individual coaching, talent development, and supportive leadership behavior are further explored | Enhancing self-awareness, individual authenticity and strengthening self-efficacy |

| Phase 3: The summer dress within reach: Lithe but fragile | Manifestation of trust, space and connectedness |
|----------------------------------------------------------|-----------------------------------------------|
| Care workers perceive more openness and share feedback more often | Vulnerabilities are shown more easily indicating trust and connectedness |
| Collaboration between the ward manager and staff improved; feelings of shared responsibility increased | Employee autonomy reflects in staff’s increased initiative-taking and improved problem-solving abilities. This indicates mutual trust, and a stronger connection between the staff and the manager |
| Improved knowledge exchange by increased interaction and structural work meetings | Care workers feel better informed, which promotes self-confidence and helping behavior among care workers |
| First signs of change become visible but need further consolidation | Improved trust, autonomy and authenticity and a stronger sense of connectedness reflect in better collaboration between care professionals (both the care staff and the ward manager), a positive and open working atmosphere, improved mutual understanding and respect, and increased work initiatives |
accept vulnerability based upon positive expectations of the intentions or behaviour of another’ (Rousseau et al., 1998: 395). This means that the trusting party is willing to accept vulnerability based on the expectation of positive outcomes. Accepting vulnerability implies that engaging in trusting action involves taking a risk to some extent (Mayer et al., 1995). However, when positive expectations are met, reciprocal behavior is likely to occur, and trust relationships can further develop. The case example gives insight into the impact of weak trust, the value of building trust and the challenge of retaining and strengthening trust.

At the start, a culture of mistrust in the ward came to the surface at both the organizational and at the interpersonal level. Strict work procedures and policy mechanisms with a focus on control and accountability resulted in a sense of distrust. The manager’s focus on compliance with rules and not involving staff in decision-making indicated a low level of trust in the care workers’ abilities. Among the staff, this low level of trust was reflected in a lack of collaboration and openness toward each other. We also identified internal trust issues among the staff, such as insecurities with regard to role behavior and performance, suggesting feelings of low self-efficacy: a (dis)belief in their own strengths and capabilities to perform tasks and affect situations (Bandura, 1977). Overall, these multiple levels of trust issues seemed to negatively impact the interpersonal work-floor interactions. By deciding to participate in the change program, the director and the management acknowledged the detrimental effects of these rigid conditions and the need to explore means for creating a more trusting and engaging work environment. Introducing the change program at the participating ward was explained twofold by care workers. Some of them felt relieved and expressed positive expectations of intentions of the initiators, laying ground for building trust (‘now we are being heard – we are getting help’). To others it was unclear why they were selected to participate in the program. They felt disqualified in a way; it felt as if they had to change because they did not perform well (‘why us?’). This perceived lack of transparency about intentions induced low trust in management and affirmed management having low trust in their abilities.

Our case example also shows how trust slowly developed at interpersonal levels. In the process, the ward manager became aware of his need to be in control and his focus on shortcomings instead of on the overall potential and individual talents. By critical reflection on his personal barriers, his personal values and his management style, he gradually learned to trust his team members’ abilities. By stimulating employees to challenge problems and welcoming their input, care workers felt they were taken seriously, which fostered a sense of shared responsibility and trust in their own abilities. Care workers gained more self-confidence by feeling valued for their expertise and knowledge. The coach also might have played a pivotal role in laying ground for trust development, whereas care workers gradually shared more work-related dilemmas and concerns. We also noticed a shift towards increased trust among the care workers, which was mainly reflected in stronger helping behavior in the ward. Group sessions, team-building events and regular work meetings created a safe environment for openness and exchange, which provided opportunities to gather evidence on each other’s trustworthiness and future behaviors (Redman et al., 2011). This created ground for mutual understanding and reciprocal behavior.
Space

We identified space as a concept that strongly relates to trust, and consider two dimensions: autonomy and authenticity. First, space can be understood as work autonomy, or the extent to which a job allows for freedom of choice and control (Hackman and Oldham, 1980). In terms of autonomy, the care workers’ space used to be strongly limited. In daily practice, they were instructed and controlled (by the ward manager) and had little decision latitude. Whereas a lack of autonomy counteracts positive work outcomes (Karasek and Theorell, 1990), perceived autonomy affects experienced responsibility for work outcomes, which are positively associated with perceived meaningfulness and job satisfaction.

In our case example, the manager played a critical role in the extent to which employees perceived autonomy and decision-making latitude. The care-giving employees were not much involved in problem-solving or decision-making and were not much recognized for their knowledge and expertise. Later on, the ward manager adopted more of a coaching leadership style; he tried to inspire and commit staff members, and he encouraged them to develop individual strengths and to improve organizational performance.

We argue that, in terms of autonomy, providing space can only be beneficial if the receiving party is capable and willing to anticipate. This requires awareness and recognition of individuals’ authenticity, which we denote as the second dimension of space. Authenticity has been referred to as ‘the unobstructed operation of one’s true, or core, self in one’s daily enterprise’ (Kernis, 2003: 1). The strong task orientation of both the manager and the care workers, and the way they expressed themselves about the team occupation, illustrate quite an instrumental stance. A strong focus on productivity and efficiency in performing tasks that meet organizational goals and requirements leads to depersonalization and feelings of interchangeability, and does not leave much room for individuality. This experience of ‘worthless competence’ (not feeling respected as a competent professional at work and in society), can even be harmful with respect to self-image and health (Elwér et al., 2010). It could be argued that a sense of self-knowledge about what makes you authentic as a person, and awareness (by self and others) about how this can be of value in work, can foster a sense of ‘valued competence’ and promote autonomous behavior. The program raised awareness about the value of individual characteristics and strengths. Care workers were challenged to no longer hide behind their masks of function and role and invited to explore their personal values, talents and intrinsic motivations. Stimulating reflectivity with regard to one’s own identity raised self-awareness and enabled self-objectifying processes such as self-knowledge, self-motivation and self-praise (Hogan and Cheek, 1983). The case example shows that appreciation and recognition of authenticity triggered autonomous behavior. This resulted in the care staff being more focused on problem-solving and taking initiatives driven by personal talents, such as taking a leading role in the kitchen and organizing creative workshops. We not only suggest that the two dimensions of space are interrelated, but also conclude that the manifestation of an individual’s autonomy and authenticity strongly depends on the extent of perceived trust at multiple levels.

Despite positive notions of autonomy and authenticity, several ambiguities rise when reflecting on the concept of space in relation to the change program itself. Although the
program philosophy was directed to create space by customization to contextual needs and development with involved stakeholders, in practice space was restricted by time pressure to develop the program, to measure output, and by fulfilling formal accountability requirements. As a result, care workers were pressed to participate in activities that were meant to improve their work autonomy but at the same time directly undermined their autonomy.

**Connectedness**

We identified connectedness as a third key concept emerging from the case, which can be seen as a positive psychological state indicating the quality of interpersonal relationships. Initially, feelings of interpersonal connectedness were low. The units operated separately, and both the staff and the manager felt isolated. The quality of interpersonal relationships may be questioned when compared with characteristics of high-quality relationships in which involved persons feel respected and appreciated and in which they perceive a sense of deep contact (Carmeli et al., 2009; Quinn and Quinn, 2002). In previous studies, connectedness with a leader has been associated with the extent to which individuals perceive a supportive and non-controlling relationship with their leader, perceive fair treatment, and feel psychologically safe (Zigarmi and Roberts, 2012). By adjusting to a coaching leadership style, the ward manager opened up for collaborative relationships with his staff, aiming to develop stronger connections with his team members. This required a sense of openness and consideration: demonstrating trust in the staff and respect for their ideas (Fleishman, 1969). Connectedness with colleagues is associated with the extent to which employees perceive interpersonal interactions with their colleagues as rewarding. These meaningful interactions foster a sense of belonging, social identity and willingness to further emotionally invest in relationships (James and James, 1989; Zigarmi and Roberts, 2012). Interpersonal connectedness between the care workers gained strength by increased social exchanges (as illustrated in the case example, through regular work meetings, joint activities, team-building, and feedback sessions). Furthermore, co-decision-making, sharing information and mutual emotional support contributed to the sense of connectedness. Care workers expressed that they had become ‘a closer team’. Overall, connectedness was reflected in an increased sense of shared responsibility, stronger feelings of being a team member, and feeling (emotionally) supported, recognized, valued and trusted.

We argue that trusting others and feeling trusted by others is of main importance in perceiving interpersonal connectedness, as well as in feeling autonomous and authentic when interacting in a mutual relationship. On the other hand, connectedness provides a safe base for trust development and for autonomous and authentic behavior. The incident in which a staff member resisted taking off her make-up in front of her colleagues is a micro-level example of the subtle interplay between the concepts of trust, space and connectedness. The make-up represents the metaphorical ‘armor’ that provided the nurse with a sense of safety, control and convenience. When she shared her personal barriers with her colleagues, they replied with understanding instead of judgments. This generated feelings of trust; the nurse felt accepted and free to make her own decision about whether or not to participate. Based on the positive expectations of the intentions and behaviors of her colleagues, she decided to show her vulnerable (and authentic) self
By doing this, she confirmed that she felt safe, which enhanced the feelings of interpersonal connectedness. This overall state of feeling connected, trusted, autonomous and authentic well illustrates the ‘summer dress’ metaphor.

**Discussion**

We identified trust, space and connectedness as important concepts regarding work-floor interaction in elderly care. These concepts helped us to understand the identified changes in workplace atmosphere, collaboration, leadership and employee involvement. Our findings suggest that the quality of working life improved by strengthening interpersonal relationships, a more open and supportive atmosphere, and improved information-sharing. More precisely, we drew the conclusion that the interplay between trust and space (autonomy and authenticity) created the required conditions to develop interpersonal connectedness. Connectedness improves the quality of relationships, which contributes to the well-being of the workforce.

In previous research, the concepts of trust (Mayer et al., 1995), autonomy (Hackman and Oldham, 1980), connectedness with both leaders and colleagues (Conley, 2013; Zigarmi and Roberts, 2012), and authenticity at work (Van den Bosch and Taris, 2014) have all been widely studied and associated with a variety of positive individual and organizational outcomes. As far as we know, the emerged interplay between these concepts has not yet been revealed and captured in a theoretical model; however, we found a commonality between our findings and Deci and Ryan’s (2000) Self Determination Theory (SDT). SDT proposes that three innate psychological needs underlie human motivation: the needs for competence, autonomy and relatedness. Satisfaction of the three needs is directly related to psychological health and well-being and motivation, and promotes effective performance (Ryan, 1995; Ryan and Deci, 2000; Van den Broeck et al., 2009). The three needs have been argued to be universal and to transcend culture and context (Chirkov et al., 2003). We briefly appoint similarities and possible additions to the mechanisms underlying need fulfillment. In line with our findings, SDT underlines the importance of a sense of choice and psychological freedom in activities (Deci and Ryan, 2000) and suggests that the interpersonal style of managers influences the extent of employees’ autonomous behavior. Although autonomous-supportive leadership is linked to employees’ trust (Deci et al., 1989; Whitener et al., 1998), SDT does not explicitly address the concept of trust, whereas our findings suggest that trust (in self, in others and received from others) is an important facilitator of autonomous behavior.

SDT’s concept of relatedness refers to the need to experience a sense of belonging and connection to other people. Similar to our concept of connectedness, it comprises the need to develop close and intimate relationships (Deci and Ryan, 2000). In addition, we suggest that the development and the quality of this interpersonal bond largely depends on the extent to which people (mutually) feel trusted, free to act (autonomous), and able to express their authentic selves.

Lastly, SDT defines the need for competence as an inner drive to gain mastery of tasks and to learn different skills. Based on our findings, we argue that the interplay among trust, space and connectedness facilitates this need and the actual accomplishment of personal growth. All in all, we stress the importance of (multi-leveled) trust as both a
prerequisite and a consequence of the three needs underlying human motivation, and we suggest that (self-) awareness and recognition of one’s authenticity play an important role in increasing competence, autonomy and relatedness. As controlling work environments have been noted to diminish employees’ experiences of autonomy, competence and relatedness (Stone et al., 2009), awareness of the interactive dynamics of trust, space and connectedness can be of important value, especially in the context of care.

Like other motivation frameworks, SDT takes a quite instrumental stance, focusing on input (fulfilling individual needs) and output (well-being and performance). We agree with critique by Kahn (1992) that these models often place emphasis on the individual and systemic components as if they can be fully controlled and directed toward the achievement of organizational goals. Contextual dynamics and the interplay of surrounding forces are often undermined and overlooked (Abma and Stake, 2014). The initial quantitative evaluation of workforce output illustrates the limitation of such an instrumental and system-oriented approach. An explanation for not detecting any improvements on pre-determined output measures was attributed to various reasons such as a weak comparability of control and intervention groups and too little time between measurement intervals to be able to capture change (Klein Hesselink et al., 2011). Although it is plausible that workforce change and development needs time to consolidate within the organizational culture, the question can be raised whether the desired outcomes of such a change intervention could potentially be captured by these defined measurements. We argue that the initial instrumental approach of measuring change effects lacks sensitivity for contradicting mechanisms within the process of workforce development, which might explain why no improvements could be measured. Constructing a naturalistic case study helped us to unravel the complexity of this change process in a specific time–location–culture context and provided understanding of its particularities and contradictions (Abma and Stake, 2014; Simons, 1996).

Our study revealed that efforts to improve both the quality of working life and the quality of care can be at odds with each other. For example, care workers learned to better empathize with residents and became more aware of individual values and vulnerabilities, which improved their responsiveness. Although greater responsiveness may be beneficial to residents and might improve the relationship between care providers and care receivers, it can also negatively impact emotional demands and work stress. Especially when one is aware of care needs but not able to respond owing to a lack of available resources (e.g. time, human resources, or money), stress is likely to occur (Veer et al., 2013). This underlines a counter-effect of skill development within an untenable system and reveals how the reductionist organization of care work conflicts with the needs of relational care (Banerjee et al., 2015). The statement, ‘we just can’t do it right’ reflects the perceived powerlessness of care workers being exposed to ‘a greedy organization’. The expression reveals that care workers developed their professional and moral values and norms, but they felt these norms could not be achieved owing to the prevailing system norms (productivity, efficiency and safety). The concept of the ‘greedy organization’ refers to organizations that make total claims on their job holders and seek ‘exclusive and undivided loyalty of their members’ (Coser, 1974: 4). Rasmussen (2004) emphasized the harmful impact of omnivorous demands on employees, especially in the case of increased responsibilities (or work autonomy) but a lack of supply and control...
over resources. The change initiative thus might have affected values and norms of stakeholders within the care system, but rather requires a paradigm shift of the system itself.

More challenges and responsibility may contribute to the perceived meaningfulness of the job, but at the same time intensifies the work and makes it harder for employees not to go beyond personal limits, in the end, for the sake of organizational gains.

This issue should be acknowledged as a serious threat for care workers’ health and well-being. It does not only result in a well-being paradox but also in an autonomy paradox.

As postulated by Menzies (1960), socially structured defense mechanisms protect from anxiety, as hierarchy, fixed roles, restricted responsibilities and routinization of work provide certainty and comfort to some extent. Care workers who were expected to act more autonomously appreciated greater trust and involvement but at the same time felt more vulnerable and exposed. When job autonomy is required to fulfill all-encompassing organizational demands, workers’ well-being, autonomy and connectedness to other circles of life are severely threatened (Coser, 1974). This stresses the need to find and develop new defense and support mechanisms.

Whereas these paradoxes will not be solved easily, connectedness between colleagues and managers can contribute to well-being at work. As illustrated in the case example, the manager positively addresses the shift from ‘problem-solver’ to feeling more shared responsibility. Care workers appreciate the more open work atmosphere by knowing each other better, feel as a closer team, and express how the exchange of information makes them feel more comfortable helping out at other homes. This emphasizes the importance of relational quality and the interpersonal connectedness of the workforce. This is in line with findings from Elwér et al. (2010), who claim that good relations with colleagues and managers contribute to the ‘social immune system of the workplace’.

The emerged interrelatedness of the concepts trust, space and connectedness also revealed a possible universal mechanism (Simons, 1996), in which ethics of care and ethics of work align. Tronto’s (1993, 2012) ethics of care stems from the idea that all human beings are vulnerable at certain moments in their lives. People are interdependent, and care is considered a fundamental human act to respond to vulnerability and maintain quality of life and well-being. Caring is a continuous and intersubjective process, and good care requires moral virtues like attentiveness, responsibility, responsiveness and trust. The process of care does not only take place between care provider and care receiver, but also applies to relationships between actors in the context of work. Ethics of care thus resonates with work ethics. We argue that the quality of working life improved because of increased interpersonal trust, the room for autonomy and authenticity, and strengthened interpersonal connectedness.

Although the impact of the workforce development on the care received was not the scope of this study, perceived change, as reported by the workforce, likely affects the quality of care in the ward positively. Although, in our case, care workers still perceived high work demands, the interviews imply that residents benefited from improved collaboration, information-sharing, and a more supportive and open work climate. For instance, now, care workers ‘dare’ to help out at other homes (as a nurse expressed in the case example).

A few study limitations should be addressed. In general, the responsive evaluation approach is valued because of its potential to facilitate a change process. By gradually
exploring various stakeholder perspectives and by creating ground for exchange, involved parties feel heard and empowered to influence the direction of change. Because this study was retrospective in nature (conducted one year after the program’s completion), it may be argued that the potential gains of the evaluation approach were limited. However, looking back to the change program and discussing perceived effects with various stakeholders (at both the individual and the group level) refreshed participants’ awareness about shared values and collective goals achieved. Such is likely to contribute to further consolidation of the initial changes.

We should also mention that, despite efforts, involving the residents in this study was difficult. Several residents who had been involved in the program were deceased by the time of the one-year follow-up, and others could not participate owing to bad health conditions or cognitive limitations. Aside from some brief informal conversations with residents, only one resident who vividly remembered the program activities was willing and able to be interviewed. As a consequence, the care-receivers’ perspectives regarding quality of care and perceived change are underreported.

We suggest several directions for future research. First, the conceptual meaning and interplay between the multiple dimensions of trust, space and connectedness should be further explored. Besides further examination of work relationships, dynamics within care relationships should be a subject of study. Further increasing care needs and persistent financial cutbacks put stronger demands on informal networks to provide care. By this changing field of forces, new interdependencies occur that will certainly affect trust dynamics, perceived space and interpersonal connectedness. We therefore suggest that, not only care receivers, but also informal care-givers, such as relatives and volunteers, should be involved in future research.

Our findings stretch beyond the local context, and are relevant for current developments in long-term care that are under pressure of further budget cuts, and the allocation of caring responsibilities to informal care-givers. We stress that in light of the societal transitions at hand, special attention should be paid to the gendered context of care. Whereas gender is a fundamental way of organizing social life, health care should also be seen as a gendered system in which men’s and women’s roles and responsibilities differ (Zimmerman and Hill, 2006). Overall, women perform the larger burden of caring roles in both the lower echelons of health care and in the private domain.

Now that health care systems rely more and more on informal care-givers, especially women in our society are expected to take responsibility for their families, neighbors and friends (Tronto, 2013). Thus, besides providing the formal care, in which workloads are heavy and status and compensation are low, women will increasingly provide unpaid informal care (Coser, 1974; Zimmerman and Hill, 2006). This places the main responsibility for both their own, as well as the care-receivers’ well-being in the hands of under-resourced women (Merens and Van den Brakel, 2014). The consequences of these accumulated burdens may be underestimated and should be further examined. For instance, caring roles expose women more often to emotional demands. Besides, in order to meet external expectations (from care receivers or the organization), expressed emotions must often be separated from felt emotions, which is also called ‘emotional dissonance’ (Hochschild, 1983; Simpson and Stroh, 2004). The suppression of negative emotions while having to display positive emotions on the
job may lead to feelings of inauthenticity. This mechanism may lead to women’s experienced job strain, because their social identity contradicts the open communication of their emotional states. Therefore, trust, space and connectedness seem especially important in emotionally ‘greedy’ environments (Coser, 1974) such as care-giving, in which workers are continuously invited to cross physical and personal boundaries of the self and others.

A few practical implications should be addressed. The change program described in this case serves as an example on how to create openings for the improvement of quality of working life. New to this approach is that it tries to keep away from conventional approaches of implementing standardized interventions following pre-fixed methods and procedures. Instead, ‘from armor to summer dress’ was developed as a context-based change program, aiming to connect and respond to contextual factors and involved actors. However, implementing this innovative approach as intended was difficult, because various tensions and contradictions came to the surface in practice. Although trust, space and connectedness were identified as valuable (relational) revenues optimizing working life, the program itself contradicted these values at some aspects. From an overall perspective, space was restricted by time pressure to develop the program, to measure output and to fulfill accountability requirements. From a care worker’s perspective, space was restricted in experiencing extra workload and pressure to participate in activities, and not feeling involved in the program development. Paradoxically, these characteristics are comparable to the armor-like conditions in care practice. The way the program was developed was initially characterized as ‘fixed’ and did not yield overall trust and full ownership from the beginning. Therefore, the program did not fully succeed in connecting all involved stakeholders. The crux is to implement such an intervention in a way that reflects the underlying goals and values (cf. Snoeren et al., 2016a). The only way to do this is through dialogue, participation and influence of the care workers during every phase of the project, joint decision-making, and continuous appreciative and adaptive facilitation. This is a process that takes time and also requires a cultural change, which appeared to be difficult to bring about in long-term care owing to the traditional and hierarchical character of organizations (Chapin, 2010). Yet another aspect specifically encountered in elderly care is that contextual dynamics are characterized by high turnover and sickness rates, small contracts, and frequent replacements in management. This implies a lack of a solid basis from which trust, space and connectedness can be easily built and further developed to sustain in the organizational culture.

Nevertheless, our case illustrates that the values slowly developed in interaction and through dialogue, through doing and experiencing, and through sharing examples and responses of the older people themselves. The program therefore set the stage for cultural change. Findings from our case study signal a transformation to a culture in which employees are encouraged to take responsibility and initiative and to participate in decision-making. Although the first signs of change have become tangible, the consolidation of these changes is still uncertain. As emphasized by Banerjee et al. (2015: 29), it is difficult to flourish relational practices in an environment where an overall reductionist stance defines ‘how care is known, funded, organized and assessed’. We draw several learnings from our study. First, cultural change ideally reflects the values it aims at; if one wants to stimulate trust, space and connectedness, the process of change should be
designed around these values (Snoeren et al., 2011). Top-down and planned approaches will not suit such a process. Co-creation and participatory action are more appropriate. Although some of the activities were indicated to be effective in workforce development (such as facilitating leadership, coaching, team-building), these specific elements seem to be of secondary importance. What matters in the first place is to create collective ownership in developing trust, space and connectedness. The method by which this is achieved depends on the context and needs of involved stakeholders. With regard to commitment and justification of costs, the development of programs should be aligned with employees’ needs, values, work expectations and backgrounds (Grawitch et al., 2006). A lack of program alignment with key stakeholders could lead to the rejection and waste of costly efforts and scarce resources. Involving external stakeholders in the change process, such as health care insurers and inspectors, could also be valuable.

Conclusion

This study contributes to the current debate about how to achieve sustainable and high-quality care for older people and how to attract and retain a satisfied and healthy workforce. In line with the development of a more humanistic framework of care (Chapin, 2010; Snoeren et al., 2016a), our findings emphasize the need to shift from an instrumental to a more relational approach. Humanization of care not only requires client-centeredness, but it should also focus on maintaining the personhood of the workforce. We need to counteract the depersonalization of care staff by recognizing care workers as authentic persons with individual talents and drives. To release residential elderly care from deeply embedded armor-like conditions, we need to strive for a care climate that fits the ‘summer dress ideal’. When further exploring and developing care practices that contribute to the well-being of both care providers and care receivers, we emphasize the importance of paying attention to the complex multilevel dynamics of trust, space (autonomy and authenticity) and interpersonal connectedness.

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