Fostering collective self-reliance in elderly care

A value-based approach to the intake conversation in homecare at Surplus

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Preface

My first reaction when this assignment in elderly care came up? Excitement, curiosity—I didn't know much about it yet, and eventually, we all encounter it. Whether it's considered a "sexy" topic or not, I see urgency, complexity, a variety of stakeholders, and a very human aspect full of vulnerability and kind-heartedness. I approached it with an open mind and with the personal goal of creating something ready to implement within 6 months, aiming to truly contribute towards fostering a caring society.

I am happy to share my work with you and hope that this project, offering a different take on care, can inspire you to get involved yourself. To try something out, together with an older person in your surroundings, to reflect, and to come up with something new again. Despite the numerous news articles and scaremongering about ageing, I remain optimistic. With many around me, I hope we can continue to tackle challenges together in a fun way. Because we're not too few people, but we're expected to reorient and share responsibilities.

I want to thank Marina and Mieke for your guidance throughout my project, your trust and the motivation to try out new things. And thank you for introducing me to designing with values and applying systemic design. Both perspectives are an addition to both my work and my free time.

I want to thank Thomas, for your involvement and for encouraging me to share my design with others in the organisation, inspiring them with a different perspective on their daily activities.

With the support of Sijmen, engaging housemates, Iris, mum and dad, graduation has remained manageable and fun. The balance between distraction and focus was key for me to achieve the thing I am proud of today. Oma Sjanie, Opa Kees, Oma Lucie en Opa Wim, thank you for being around.

And finally, oma Frankrijk, where I rang your doorbell 6 years ago to test my first prototype for IO, I was there again last month, testing my final project with you. After walking around IO for 6.5 years, it feels nicely rounded for me. I look forward to a new adventure where I want to use design and a systemic perspective to tackle societal challenges and contribute to the cultural sector.

Enjoy reading, and as a teaser, I'd like to share a quote from Jan Kremer, Professor and Special Envoy for Appropriate Care, whom I recently spoke to about the importance of working together on solutions. 'We need to ensure that you find other perspectives not irritating but interesting and that they are useful for taking next steps. And this also requires an attitude of curiosity, connection, and, indeed, humility.'

Ianthe van Alkemade

Summary

This project responds to the increasing challenges in Dutch elderly care amid an undeniable ageing demographic. Between now and 2040, the number of individuals aged 80 and over will nearly double, and one in four people will need to work in the healthcare sector to satisfy the increasing demands.

The current system of elderly care is very much solution-focused, where professional caregivers often provide the answers and lead the discussions. Organisations like Surplus, a care and welfare organisation in West Brabant, struggle to continue to meet the expectations of (new) clients and their relatives, placing an additional burden on professional caregivers.

The increasing pressure highlights a need for greater autonomy and shared responsibility in elderly care. The urgent and multifaceted nature of the current challenges calls for a 'new way' of caring, with a greater reliance on answers from society. This project envisions a shift towards a caring society that focuses on what is still possible rather than on limitations, aiming for a meaningful life. Where self-reliance is a collective effort, and each individual is truly recognised.

Through a systemic design approach, this project seeks to navigate these challenges by uncovering key personal values in receiving and providing care and mapping out the elderly care system to identify opportunities to intervene. An intervention that incorporates these values is designed to initiate a shift towards the desired direction.

To facilitate this change, I have developed a new approach for Surplus to have value-oriented conversations, to match what we find important in life. Inviting people to think beyond the care question and to look together at what is possible instead of what is no longer possible. Transitioning from a traditional "intake" in home care to "acquaintance", it introduces the T-Doos (Tijd voor gesprek, Thee voor twee, Langer Thuis: Time for Conversation, Tea for Two, Staying Home Longer) personal preparation package with a conversation box and a conversation framework. This invites the elderly in need of support to think together with their informal carers about what is important to them in daily life, who they are in contact with, what makes them happy and how they look ahead. It sets the stage for meaningful discussions with district nurses to collaboratively explore possibilities. The professional caregiver adopts a coaching role, and a transition is started in mindset and practice within care organisations and among healthcare professionals.

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Glossary

Below are terms frequently mentioned throughout this report, along with their definitions as interpreted in the context of this study:

Care recipient	Elderly individuals in need of support, including those already receiving (professional) care.
Future care recipient	Used to describe my study participants as individuals who do not currently need support but are likely to in the near future.
Professional caregiver	Includes nurses, doctors, and other healthcare professionals providing care as their occupation.
Informal carer	Relatives (e.g. family members or friends) providing unpaid support and care to the care recipient.
Receiving care (verb)	Activities where an individual receives support, ranging from companionship to professional care.
Providing care (verb)	Activities where an individual offers support, from companionship to professional care services.
Elderly	A term referring to the segment of society affected by aging, typically considered 65 years and older according to CBS (Centraal Bureau voor de Statistiek, 2016). However, this is not a fixed definition, acknowledging the diverse health conditions and varying rates of aging among individuals.
Caregiver	A general term for anyone providing care, whether informally or professionally.
Client	Used to refer to care recipients that are currently receive care from a specific care organisation like Surplus. It highlighting the professional and service-oriented relationship.
Home care	Assistance provided at home, from domestic help to nursing care, aimed at maintaining or improving the quality of life and avoiding institutional care (Ministry of Health Welfare and Sport, n.d.-a).
Intake	The initial discussion with a care organisation like Surplus to identify the necessary support for new clients.
District nurse	A healthcare professional acting as the main point of contact for care and welfare in the community. With a holistic view, the district nurse assesses support needs, which may include home care assistance, looks beyond considering broader community resources like neighbours, family, and volunteers (Ministry of Health Welfare and Sport, n.d.-b).
IZA	Integraal Zorgakkoord (Comprehensive Care Agreement, IZA). An agreement between the government and healthcare organisations to improve and future-proof healthcare, focusing on reducing the overall need for care.(Ministry of Health Welfare and Sport, 2022a).
WOZO	Wonen, Ondersteuning en Zorg voor Ouderen (Housing, Support, and Care for the Elderly). A government program in which various parties in elderly care set a new standard: 'by yourself if you can; at home if you can and digitally if you can'(Ministry of Health Welfare and Sport, 2022b).

01

Chapter 1

Introduction

This chapter lays the groundwork for this thesis, introducing why it was initiated, the initial project objectives and outlines the project approach. It serves as a navigational guide for the remainder of the report.

1 | Introduction

The rising pressure on healthcare in the Netherlands, driven by a growing elderly population, caregiver shortages, and strained public finances, challenges the obviousness that care will always be readily available. This demands a shift towards greater autonomy and shared responsibility in elderly care. A shift in perspective is needed, focusing on living a meaningful life over seeking professional care solutions.

In this context, Surplus, an organisation providing comprehensive elderly care services in West Brabant, faces questions about its role in adapting to evolving responsibility and autonomy in elderly care. The ageing wave and its plans like IZA, Integraal Zorgakoord (Comprehensive Care Agreement) (Ministry of Health Welfare and Sport, 2022a) and WOZO, Wonen, Ondersteuning en Zorg voor Ouderen (Housing, Support, and Care for the Elderly) (Ministry of Health Welfare and Sport, 2022b) focusing on reducing the overall need for care and on increasing self-reliance, are given, but its interpretation remains open, leaving an opportunity for designers and other practitioners in social innovation to help in shaping its direction. The formation of this project stems from the challenges faced by Surplus' care professionals in conveying the importance of clients maintaining their self-reliance for as long as possible. Despite their efforts, conversations often result in disappointment or surprise from clients and their relatives, who feel they have a right to receive care. Caregivers take the hit these reactions, even though it's a broader social shift. This raises the initial question: "How can expectations between caregivers and the elderly who need care be aligned better, while preserving caregivers' job satisfaction?"

In this graduation project, I adopt a design-driven approach to answer how we can continue to look after each other in a pleasant way, focusing on the values that are important to us. I explore essential values in receiving care and providing care and in the relationships between care recipient and caregiver. I will investigate what values and relationships are put under pressure in the changing landscape of elderly care. Accordingly, I will propose an intervention as one of the steps for Surplus to navigate a systemic shift towards the desired direction as formulated in the course of this thesis.

1.1 Initial project goals

1) Identify and address values related to elderly care and minimise potential conflicts during the shift to greater autonomy and responsibility for the care recipient and their social network.

2) Design an intervention that consciously incorporates these values, assisting Surplus in guiding the shift to a new care standard.

1.2 Project stakeholders

This project is carried out in collaboration with Surplus, within which I am part of the Social Innovation team. I am in frequent contact with those directly involved in elderly care: existing care recipients, professional caregivers, informal carers, and prospective clients. Additional stakeholders relevant to the project's goals and progress will be identified and engaged as necessary.

1.3 Project approach

In this project, I combine a value-based approach with systemic design to address elderly care's complexities efficiently, aiming for actionable outcomes for Surplus within a six-month period. This process entails zooming in on individual values and zooming out to understand the broader systemic context, identifying where small interventions can initiate a systemic shift. This approach is grounded in systems-shifting design, which van der Bijl-Brouwer describes as *'The basic idea of systems-shifting design is that a vision is generated which represents a 'directionality' in which we want a complex system to move.'*(2023)

This idea stems from systemic design, an evolution of systems thinking and design methodologies, guides this process. Systems thinking provides a way of looking at systems as indivisible wholes, recognizing their interconnectedness (Jones & van Ael, 2022). Systemic design, however, is action-oriented, applying an evolutionary 'probe, sense, and respond' aiming to facilitate systemic change (Bijl-Brouwer & Malcolm, 2020; Snowden & Boone, 2007). This approach is not fixated on finding immediate solutions but rather focuses on identifying 'leverage points' within the system to guide it towards a desirable new direction, thereby working towards (re)balancing the system as a whole (D. H. Meadows, 2008).

The structure of my project, with systemic design weaving through it, is detailed below and visually represented in Figure 1 to guide you through this report.

It starts with an exploration of the current dynamic in elderly care, including Surplus' role and various views and plans to address challenges. Through understanding these dynamics, I formulate a desired directionality, that this project aims to contribute to.

Next, I zoom in, investigating the values involved in both receiving and, through focused interviews with those directly involved. With the insights from this analysis, I define the system boundaries.

Subsequently, I zoom out to map out the elderly care system to seize opportunities to intervene. This involves looking into key actors and their interrelations, refining my system boundaries and pinpointing leverage points within the system where even small interventions could lead to shifts towards our desired direction.

A design phase follows, creating intervention ideas based on these leverage points. This phase involves an evolutionary design process of brainstorming, analysing current processes and tools, prototyping, testing, and iterating with end-users.

Next, I introduce the final intervention.

In the concluding sections, I outline what is needed for short-term implementation and discuss the potential long-term implications of the intervention. Acknowledging that changing system-shifting necessitates long-term commitment due to the gradual and slow changes in complex systems (van der Bijl-Brouwer et al., 2021), I propose strategies to facilitate this shift.

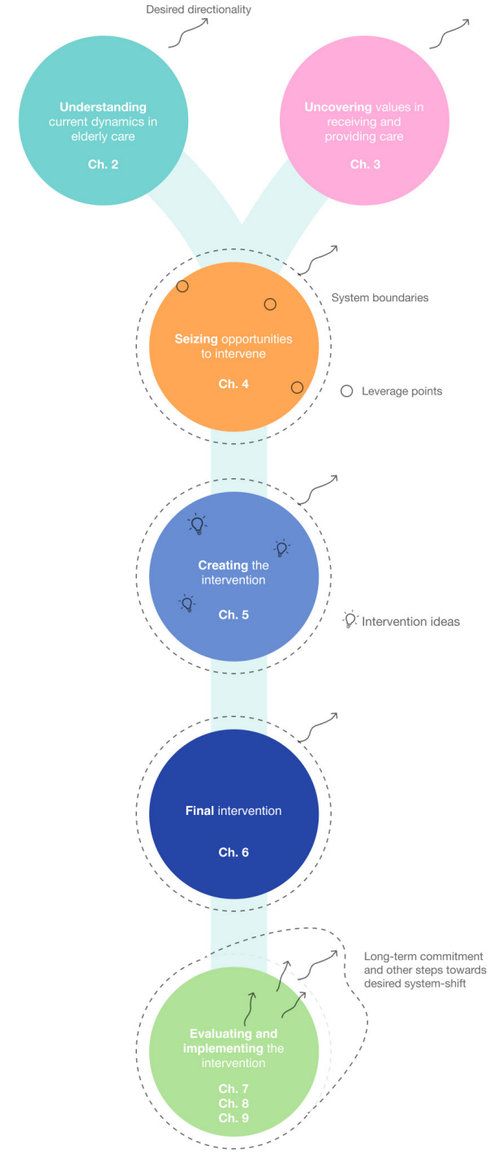

Figure 1, 6-step approach of graduation project including the corresponding chapter.

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Chapter 2

Understanding current dynamics in elderly care

This chapter provides background information on elderly care in the Netherlands and Surplus as the organisation relevant to the graduation project. It outlines current plans and beliefs in response to the challenges in elderly care and maps Surplus's activities and organisational structure. This aims to understand the context upon which my design is built and the organisation for which the design is intended to support in navigating towards the desired direction, which will be formulated at the end of this chapter.

2 | Understanding current dynamics in elderly care

2.1 Challenges, plans and views on elderly care

2.1.1 Current challenges in elderly care

Ageing wave comes with many challenges

The Netherlands is ageing, meaning that the number of people aged 65 and older is growing with a decreasing number of working-age individuals, as shown in FIgure 2 (Centraal Bureau voor de Statistiek, 2016). Due to factors like the baby boomer generation, the number of individuals aged 65 and older is expected to increase from 3.5 million to 4.8 million between 2023 and 2040 and the number of those aged 80 and older will almost double during the period from 2020 to 2040 (Rijksoverheid, 2020). The impact of this ageing population is particularly acute in regions like West Brabant, the focus of this project, where the ageing rate exceeds that of other provinces (RIVM, 2022). Additionally, improvements in healthcare quality and accessibility are leading to longer life expectancies, expected to reach nearly 86 years by 2040. Once life-threatening illnesses are now chronic conditions due to healthcare innovations. While many older adults remain independent, others will require more support, leading to increased demand for long-term care services (Mouchaers et al., 2023). Despite some enjoying good health and quality of life due to healthcare advancements, the Netherlands faces significant challenges due to shortages of employees, volunteers, informal carers, and suitable housing, which are all expected to get worse (Nationale DenkTank 2023, 2023).

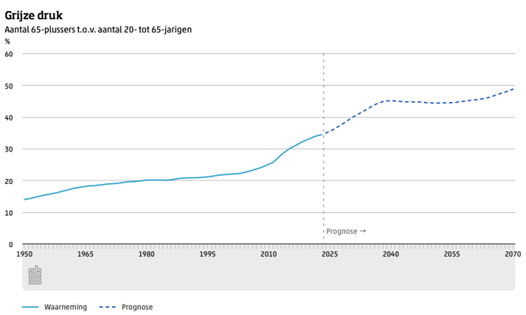


Figure 2, Grey pressure in the Netherlands: Number of over-65s vs. number of 20- to 65-year-olds (Centraal Bureau voor de Statistiek, 2023)

Shortage of people providing care and an informal carer potential

Given the current organisation of healthcare in the Netherlands, projections indicate that by 2040, one in four individuals will be required to work in the healthcare sector to meet rising demands. This translates to the need of approximately 40,000 additional healthcare professionals annually (Rijksoverheid, 2020). In addition to shortages in professional care, both Dutch family culture and the formalisation of long-term care contribute to the lack of obviousness to care for a loved one. According to the European Value Study, only 16 percent of Dutch people believe that children should care for their parents when they need care or assistance, the lowest percentage in Europe (Halman et al., 2022). Changes in societal norms, smaller families, and increased distances between generations could have contributed to this, or it may stem from the expectation that others will provide care. As such, compared to other European countries, the Netherlands spends significantly more on long-term care (State of Health in the EU, 2021)

Additionally, there is a conflict in what the government asks of its inhabitants. On the one hand, there is a call for increased work due to shortages, while at the same time, there is a demand to care more for others. The latter necessitates more time in one's life to take on caregiving duties, but daily life often gets in the way. However, recent research by Rudi Westendorp suggests that, on paper, there is sufficient potential among informal carers, particularly among the elderly population due to the ageing wave (van der Geest, 2023). And retirees seem to have more spare time. Yet, it remains unclear how to effectively use this potential. Research indicates 8 out of 10 informal carers experience meaning or pleasure ("zingeving") in their role, alongside the substantial informal carer potential, suggesting a promising opportunity (Haisma, 2023). Still barriers exist, such as question shyness ("vraagverlegenheid"), meaning that people find it difficult to ask and/or accept help from others. Behr, a participants of the Nationale Denktank 2023, encountered this in practice: 'I noticed it at the GP center. Often, an elderly person has a family but they live far away. "Can't your neighbours give you a lift?' I would ask. 'I'm not sure if they would want to do that,' was often the response. And later those same people would call back saying the neighbours didn't mind at all." (Hoekwater, 2023)

Shift in responsibility to live a good life in times of the ageing wave

As the societal demand increases for individual contributions to elderly care, there is a shift in responsibilities taking place. According to Actiz's public report, Dutch citizens currently tend to externalise this responsibility, while they do indicate a willingness to care for themselves or others as shown in Figure 3 (2023). It remains a sensitive issue as it concerns care for the vulnerable, and the pressure has essentially become a societal problem. However, opinions vary on who is responsible for addressing the current issues. Within the plans, various perceptions and initiatives discussed in Section 2.2 also present different perspectives on who is responsible for what and how this can manifest.

Partitions within the elderly care system hinder necessary transitions

The partitions in legislation and financing present significant challenges in bringing about change in elderly care, making it difficult to collaborate across domains or take a holistic approach essential for transitioning to appropriate care (den Draak & Plaisier, 2021). As such, the partitions do not always align well with the unique situation of elderly who experience problems in their daily lives. Additionally, partitions in funding streams lead to risk-averse behaviour due to budget constraints, sometimes resulting in elderly being transferred from one care provider or professional to another.

Figure 3, Perception on responsibility for care in the Netherlands, from factsheet public reporting by ActiZ (2023).

2.1.2 Current plans and views on how to address the ageing wave

Despite the obvious urgency to address the ageing wave, recent research by De Nationale DenkTank 2023 suggests that Dutch governance lacks a coherent vision with concrete actions (2023). Nevertheless, among the government plans, the IZA and WOZO are guiding principles for Surplus, as outlined below. Additionally, several organisations in elderly care as well as research institutes and consultancies are actively seeking alternatives. To understand the variety of perspectives on how to cope with the ageing wave and which organisations support these views, I created an overview in Table 1. I developed this table by consulting a wide range of sources, including news articles (e.g. Volkskrant, NRC), podcasts on innovations in elderly care (e.g. Onderweg naar Zorgen), visions and strategies from trade organisations (e.g. Actiz), insurers, and care offices, and governmental reports and visions from knowledge institutions (e.g. Movisie). This method involved iterative clustering of the various views intuitively, so the table isn't fully exhaustive and some overlap between perspectives exists. However, it does picture the key differences, focuses and potential directions for elderly care. For example, while elderly care organisations focus on the welfare of care professionals, trade organisations stress technology to enhance self-reliance, similar to healthcare technology providers. Patient federations and knowledge institutes advocate for prioritising elderly individuals and embracing their diversity. The need for better integration in policies among care administration offices, insurers, and municipalities is becoming increasingly apparent. Despite these differences, the views can complement each other in working towards a common end goal which can only be achieved by 'caring differently' (J. Kremer, personal communication, March 18, 2024). Common among both government plans and other views is the shift in societal focus towards positive health, prevention, and maintaining independence. It is also a shared ambition to move towards a caring society. As described by Westerlaken from ActiZ: "We need each other, society, and political The Hague, to address this significant societal issue." (Westerlaken, 2023).

IZA 'Working together towards healthy care'

In the Integraal Zorgakkoord (Comprehensive Care Agreement, IZA), agreements have been made between the Ministry of Health, Welfare and Sport and several large healthcare parties (social services, GP, community care, GGZ, and hospital services) on how to maintain the delivery of quality curative care (de Vetten, 2022). The starting point is healthy lifestyle and prevention. IZA suggests to fully engage in appropriate care (passende zorg) to safeguard the future quality of healthcare in the Netherlands, ensuring that everyone can continue to receive the necessary care (Ministry of Health Welfare and Sport, 2022a). Appropriate care is value-driven, focusing on health rather than illness, considering what individuals are still capable of and what they believe contributes to a fulfilling life (Zorginstituut Nederland, 2022). It organises care as close as possible to the care recipient, fostering shared decision-making for support that aligns with their preferences and abilities (Shared Decision Making, Samen Beslissen). While healthcare and well-being are often separate, they become more integrated within appropriate care. After all, it is also about preventing illness which often goes beyond providing care itself, such as supporting people in their own neighbourhood or environment and through relatives or neighbours (Zorginstituut Nederland, 2024).

The IZA calls for closer collaboration between the care domain and social domain. Additionally, the IZA aims to increase the job satisfaction of care workers to retain them in care.

WOZO

The WOZO program (Housing, Support, and Care for the Elderly) primarily focuses on promoting self-reliance among older adults to contribute to the future sustainability of elderly care (Ministry of Public Health Welfare and sport, 2022). This demands a lot from the social domain in particular. The guiding principle is: self if you can, at home if you can and digitally if you can.

> In the conclusion of this chapter, I will discuss which views on elderly care this research will build upon, through the formulation of a desired directionality. These views will serve as the foundation for the directionality the to-be-designed intervention aims to contribute towards.

Table 1, A collection of various views on addressing the ageing population and the corresponding stakeholders.

View	Description of view	Supported among others by:
Embracing Smart Care ("Slimme Zorg") and accelerate digitalisation of healthcare	Accelerating technological innovation is crucial for reorganising healthcare, ensuring the right care is delivered with fewer staff. Digitisation of healthcare to help people stay independent longer and have more control over their lives (ActiZ, 2024a). Think of innovations like healthcare technology, e-health, and digital care.	• Trade organisations in elderly care, such as ActiZ and VGZ • Healthcare technology firms • Ministry VWS (Zorg van Nu, n.d.)
Changing the current mindset: Rewarding non-professional care actions	Instead of solely relying on professional caregivers, it's important to think about what seniors need to be happy as they age, without making every aspect of elderly care too focused on professionals. Currently, costs are mainly based on a price/volume model, with which we are now rewarding professional action, when non-action may actually be more appropriate care, which requires a holistic approach (Kremer, 2023). Thus, the focus should be shifted, more human and less patient (Netherlands Patients Federation, 2018).	• Researchers and experts active in topics related to future of elderly care • Patient federations
Elderly as the solution and embracing diversity: 'The elderly' does not exist'	"Let's together amplify the voice of the growing elderly population" (De Seniorencoalitie, n.d.). Currently, elderly are often perceived as the problem. But what if we see elderly not as the problem, but as the solution? There needs to be a change in the negative perception of the elderly (Linders, 2023). In our society, older people are still often viewed as a homogeneous group. However, it's important to recognise that "the elderly" does not exist, and to embrace their diversity, especially as we face increasing demands on each other. This diversity includes differences in age, cultural and religious background, level of education, income, and dependence on care (Nationale DenkTank 2023).	• Seniorencoalitie • Research institutes
Recognition and trust in healthcare workers	In the increasing pressure on the care system, the workload needs to be lightened to make the job enjoyable again. Absenteeism is very expensive as noted by Leensen (NOS, 2023). It's essential to prevent staff from being overwhelmed by protocols and administrative burdens, as this contributes to a negative image which reduces interest in working in healthcare. To address this and enhance employee well-being, giving a voice in the workplace and fostering trust are necessary (van Huystee, 2022).	• Consultancies (e.g. EY) • Trade unions, such as V&VN • Trade organisations in elderly care, such as ActiZ and Spot • Elderly care organisations (e.g. Surplus)

View	Description of view	Supported among others by:
Prevention and integration of care for an effective care chain	Currently, healthcare is mainly reactive and is lacking a focus on prevention (e.g. Advanced Care Planning) and early detection (“vroegsignalering”), while it is crucial to preventing people from needing more or heavier care (Veldman, 2018). Parties like insurers, municipalities, and care providers lack incentives because the benefits are often only noticeable later and may not always benefit the party bearing costs due to barriers between healthcare sectors (Rijksoverheid, 2020). Integration across sectors is crucial to establish an effective care chain for vulnerable elderly (CZ Zorgkantoor, 2023). Alignment of policies between care insurers and care administration offices is necessary to ensure appropriate care for the elderly and prevent elderly from falling through the cracks (e.g. Wlz, Zvw and Wmo care should be better connected) (NZa, 2022).	• Verzekeraars en zorgkantoren (CoöperatieVGZ & Zorgkantoor, 2022; CZ, n.d.; ZN, 2023) • Government interest in prevention (RIVM, 2017b) • Supervisors in healthcare (on care providers, health insurers, care administration offices and the CAK), e.g. NZa.
Reablement as guiding: from care to everyday life	Reablement is an approach where caregivers help older people live their own lives in the way they prefer, aiming to regain and maintain their functional ability and independence (Reable Nederland, n.d.). Following its success in Denmark, where it is actively implemented, the concept of Reablement is attracting growing interest and has been incorporated into various plans.	• Zorgkantoren (e.g. Zilverenkruis) • Knowledge organisations for care and support (e.g. Vilans) • Elderly care organisations

2.2 Surplus’ role within elderly care

2.2.1 Who is Surplus and what do they do?

Surplus provides a comprehensive range of services in residential care, home care, treatment, and well-being across 16 municipalities in West Brabant. The organisation is supported by a team of 3000 employees and 2500 volunteers, with an annual turnover of 180 million euros (Surplus, 2022).

Their governance philosophy, working from the perspective is:

‘Zie mij’ (see me)

“To understand each other, you must first truly see the other person. Only then can you act based on their needs.”

surplus

Surplus operates through two divisions: the Care Domain and the Well-being Domain. The Care Domain encompasses services such as home support, home care including district nursing, and complex care in various specialisations such as somatic and dementia, as well as residential care. This division primarily focuses on individuals aged 55 and above. On the other hand, the Well-being Domain caters not only to the elderly but also to all other age groups. It includes services like social work, informal care, community centres, activity centres, and youth work. Additionally, policies and funding vary by municipality. For instance, the social domain is funded through the WMO (Social Support Act) by the local government, and the amount allocated to the social domain differs from one municipality to another.

The focus on values in this study aligns with Surplus’s relatively unique position in Brabant, which combines care and well-being. This offers opportunities to enhance clients’ meaningful lives by prioritising values. And it allows them to take comprehensive responsibility across various areas. The organisation is currently shifting from individual-focused care within its facilities to a more community-centric approach in neighbourhoods, underlining the integration of care and well-being services.

Due to budget cuts in healthcare, driven partly by aging populations and inflation, Surplus is currently implementing cost-saving measures (aiming for a 5% reduction in 2023) (T. van der Vange, Personal Communication, October 3rd, 2023). However, in the long term, they plan to shift towards a more social approach, integrating nurses with social workers, for instance.

2.2.2 How is elderly care arranged in the Netherlands?

Given the complexity of the elderly care system, involving numerous actors, laws, and financing structures, the focus lies on the relevance of this project and its connection to Surplus’s role in the elderly care system. Elderly care in the Netherlands is governed in partitions by three laws: the Health Insurance Act (Zvw), the Long-term Care Act (Wlz), and the Social Support Act (Wmo) (Kraaijeveld & Wessels, 2018). Also, the financing for care and support is arranged through three funding streams, including municipalities, health insurers, and care administrative offices. This is in the form of an escalation model, which is decisive for elderly care, and thus also for Surplus. These laws and finances determine the type, amount, and timing of care an elderly person can receive. Based on their level of care dependency, as indicated by parties such as their GP, a district nurse, or the care office (zorgkantoor), individuals receive the support they are entitled to. Figure 4 provides a schematic overview of the pathways for an elderly person in need of support and includes Surplus’ contribution.

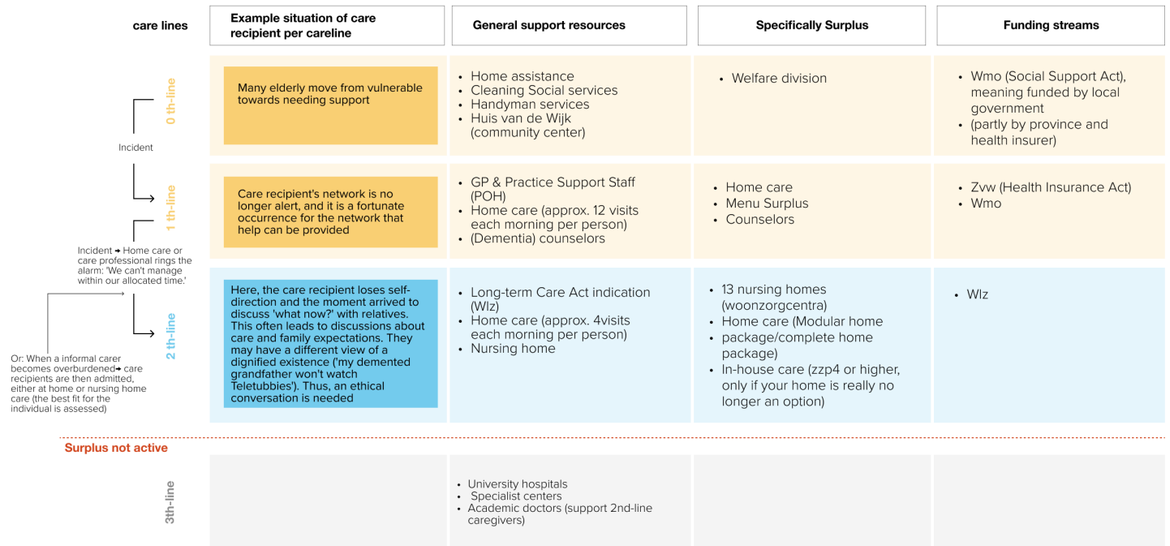


Figure 4, Overview of available support and care for elderly in need of care through various care paths. Including Surplus’ services.

2.3 Conclusion and desired directionality

After having explored various perspectives on elderly care and gathered a deeper understanding of Surplus and its core principles, I have formulated the following directionality for a desired system shift in elderly care.

Navigating towards a caring society that focuses on what is still possible rather than limitations, aiming for a meaningful life. Where self-reliance is a collective effort, and each individual is truly recognised.

This directionality emerges from the focus of my study on providing and receiving care, reflected in the value-based approach of appropriate care (as outlined in the IZA). Aiming to make a meaningful life possible with an optimistic view and focusing on the person rather than just solving medical issues. It aligns with Surplus's principle of "Zie Mij (see me)", covering clients, their relatives, and staff, making sure that work stays enjoyable and fulfilling. With a shortage of hands to provide care, I believe care should be a wider collective effort, demanding a shift towards a society where collective self-reliance is key, building on WOZO's focus on autonomy and self-reliance but expanding it to collective efforts. In contrast to our increasingly individualistic society, this directionality represents a shift towards a caring society, wherein we look after each other in new ways.

This directionality forms the initial part of the 'Frame of Reference,' guiding the design of the to-be-designed intervention, as shown in Figure 5. This Frame of Reference aims for shared meaning and understanding among project stakeholders (Ryan, 2014). I construct this frame through iterative cycles (Schön & Rein, 1994) and supplement throughout this report. All blocks in the reference frame correspond to the chapter colour from where it originates from.

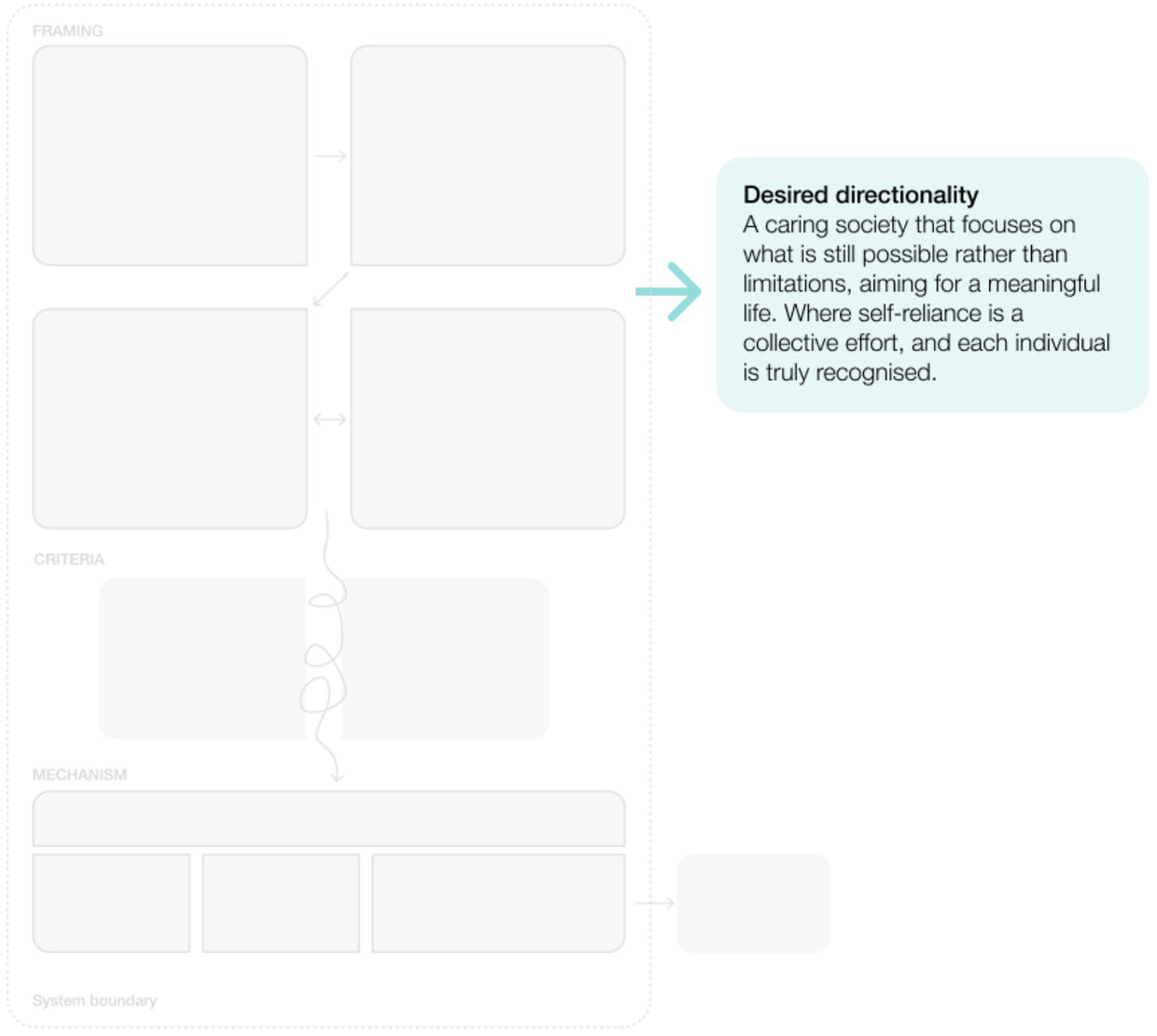


Figure 5, Reference Frame version 1, including the desired directionality

03

Chapter 3

Values as lived experiences: uncovering values in receiving and providing care

In response to the need for broader involvement beyond professional caregivers and healthcare organisations, this chapter aims to uncover the values involved in both receiving and providing. It investigates potential value conflicts arising due to the increasing pressures within elderly care, aligning with the project's initial goal 1: identify and address values related to elderly care and minimise potential conflicts during the shift to greater autonomy and responsibility for the care recipient and their social network. This is done through 11 semi-structured interviews on the lived experiences of professional caregivers, informal carers and (future) care recipients, followed by thematic analysis. Based on the study insights, system boundaries are defined.

3 | Values as lived experiences: Uncovering values in receiving an providing care

To understand the action of receiving and providing care, I delve into the values held by those directly involved in elderly care, factors that influence their perspectives and life choices. This is done through exploring the lived experience of those directly involved in care, focusing on a reflective approach rather than real-time observations (Cassidy et al., 2011). Here, specific experiences related to care are recalled and analysed retrospectively, allowing participants to reflect upon and articulate moments of care either received or provided. This aims to reveal the underlying values important to each person in those specific contexts.

Through uncovering values, it can be explored how the care responsibilities of current care recipients and caregivers can be shared among multiple individuals, such as the care recipients themselves, communities, or other resources, all while respecting the values held by both parties involved. Figure 6 illustrates this expansion of the caregiver role. In practice, these identified values may fuel questions such as which values should still be fulfilled by professional caregivers and which could be supported by one's social circle. Figure 7 shows an example of the desired shift towards more shared responsibility, where there is no clear distinction between caregiver and care recipient roles.

Given the already notable pressure in elderly care, mapping the present values could potentially reveal value conflicts. For example, a care recipient's desire for personal contact and laughter could clash with a professional caregiver's time constraints (having to achieve more visits in less time), despite mutual joy. With this overview of values, Surplus could put its efforts into alleviating current clashes and preventing future value conflicts, while simultaneously exploring ways to deliver value-based care, as advocated in the IZA.

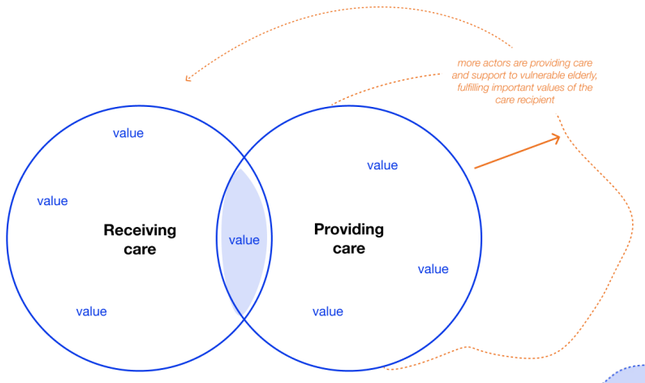


Figure 6, Values in receiving and providing care

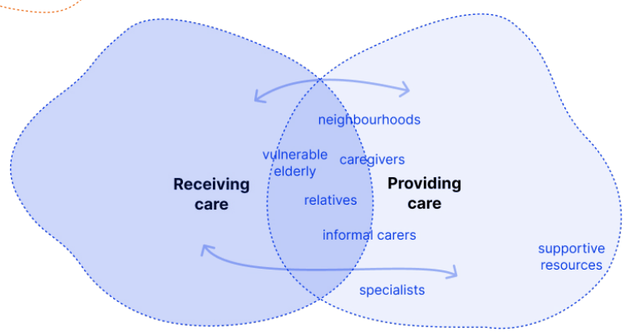


Figure 7, shifting roles towards more shared responsibility in caring

3.1 Objectives

This study aims to explore which values are important for the participant in the context of receiving care or providing care and how they play a role in current developments in elderly care. This study has the following two objective:

O1: To uncover which human values are currently present in receiving and providing care, identify overlap or conflicts across participant groups, and analyse how these values may come under pressure now and in the near future.

O2: To identify the current challenges faced by both care recipients and caregivers and determine what is most important for them to preserve in receiving and providing care.

3.2 The relevance of exploring values

Before delving into the exploration of values, a deeper understanding is needed of what values mean and how they matter in this context.

Values themselves can be described in many different ways and differ across domains. While the term is widely used, it is not well understood (Den Ouden, 2012). Where in some cases 'value' can represent a certain amount of worth of objects or projects, in this context of the human action of receiving care and providing care, 'value' is used to refer to the ideals that people have (Bos-de Vos, 2020); conveying what is important to people in their lives (Bardi et al., 2009). Every person holds various values. The way in which values are prioritised by importance relative to one another characterises one as an individual, because this influences perceptions, attitudes, and behaviour (Bardi & Goodwin, 2011; Rokeach, 1973; Schwartz, 2012). As a starting point, this study adopts one of the most influential theories, namely Schwartz's theory of human values (Schwartz, 2012)..This theory outlines ten distinct values that people use as guiding principles for their actions and activities: power, achievement, hedonism, stimulation, self-direction, universalism, benevolence, tradition, conformity, and security. These human values are related to each other and either reinforcing or conflicting, a schematic overview is shown in Figure 8. For example, benevolence and power, conflict with one another, whereas others, such as conformity and security, are compatible and reinforce each other.

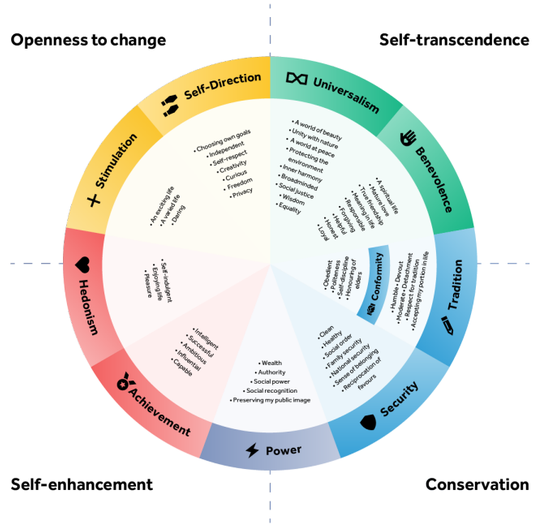


Figure 8, Schwartz model of Universal Human Values (BOOM Strategie en Communicatie, 2023)

Dynamics of value change

While human values are universally structured in compatibility and conflict between values, there are different views on how stable these values are for an individual. Some studies suggest minimal change in values over time (e.g., Lubinski et al., 1996; Schwartz, 2005). In contrast, other studies suggest that individual values can change more easily (Kohn & Schooler, 1982; Sheldon, 2005), especially after big disrupting life events (Steinert, 2021; van der Poel, 2022). The context of this study aligns more with the latter perspective. For example, the end-of-life phase for the elderly introduces various new experiences, including the loss of control over one's body and shifts in relationships. Additionally, the increased pressure on elderly care necessitates change and adaptability from many people.

Creative ways to uncovering values through lived experiences

Values are often expressed as abstract ideals and have an unconscious influence on our behaviour at a certain time of action (Bardi & Schwartz, 2003; Van Der Weij et al., 2023). Creative research methods are used to cope with the abstractness and unconsciousness of values. As designers' capabilities help analyse and visualise

complex phenomena and processes (Bos-de Vos, 2020; Dorst, 2011), I apply my design capabilities to craft instruments to use in the interviews that enable participants to revisit and share their lived experiences in a tangible way. Among other tools, I will be using Playmobil to sketch out specific caregiving scenarios, shown in Figure 9. Through this concreteness, I aim to make it easier for participants to express underlying reasons for specific behaviours, revealing their values, and thus what they genuinely find important in receiving care and providing care. Furthermore, this approach allows me to 'enter the participant's world', understanding their thought processes and language to express their experiences. This understanding can help in interpreting stories to translate them into values (Freeman, 2008).

A set of values representing the study's context

A set of values representing the study's context

It is important to mention that I am using Schwartz Human Values as starting point and guideline, not as a strict rule. Instead, my study is open to exploring and gradually collecting a broader set of values that represent the study's context. This flexibility enables me to consider values not only at an individual level but also as collective social or cultural phenomena (van der Poel, 2022). For instance, a care recipient highly values their independence and the one of their relatives, conflicting with societal expectations that advocate seeking help from relatives. Additionally, it allows us to discover the presence of relational values, derived through people's interaction (See et al., 2020), especially in caregiving, where two or more people are involved.

Figure 9, Creative research instrument for during the interviews, using an template and Playmobil for adressing the interaction of receiving and providing care during the going to bed moment

3.3 Method

In this study, I employed a qualitative research method, using semi-structured interviews complemented by creative research instruments. These instruments were focused on one specific care moment to relive and enable conversation on lived experiences in care, namely the going to bed moment, comprised of a template and Playmobil as shown in Figure 8. This approach allowed me to capture rich and meaningful insights from the experiences of participants in their natural context (Kitto et al., 2008). Within the qualitative method, I incorporated both a hermeneutic approach and thematical analysis, which allowed for a for a deep exploration of participants' lived experiences and perceptions related to care. This facilitated the identification and interpretation of underlying values (Boenink & Kudina, 2020). The thematic analysis helped to identify patterns within the interview data, revealing themes related to understanding experiences in care from both recipients' and caregivers' perspectives (Boyatzis, 1998; Myers, 2004).

Prior to conducting the interviews, I immersed myself in the living and working environment of the participants. This involved shadowing nurses, visiting residents in a care home, and participating in a community meeting at a care home (with future care recipients). These activities provided me with a foundational understanding of the participants' daily lives and the contexts of their care experiences (Eriksson et al., 2021).

A schematic overview of the research process is presented in Figure 10. For the thematic analysis I drew inspiration from the methodology for thematic analysis by Braun and Clarke (2006) , offering a structured and still flexible approach to data interpretation.

3.3.1 Participants and recruitment

To understand the perspectives in receiving care and providing care, the study involved 'experts by experience', to represent the care recipients, future care recipients, professional caregiver and informal carer.

The current care recipients lived in a care home at Surplus (intramural), required care due to physical condition (somatic complaints) and had a **ZZP-4** indication or higher.

> A **ZZP** (ZorgZwaartePakket) indication refers to a specific classification used to assess a person's care needs, indicating the type of care required and the number of hours available per week for it (WZU Veluwe, n.d.). The Center for Indication of Care Needs (CIZ) categorises from ZZP1 to ZZP10 (ranging from low to high dependency care). ZZP4 applies to care recipients with somatic or psychogeriatric complaints, who require protective housing with intensive supervision and extensive care (RIVM, 2017a). Currently, ZZP1-ZZP3 are funded through the WMO, while ZZP4-ZZP10 fall under the WLz. However, this may change in the near future due to policy shifts

This focus stemmed from policy changes, which makes that new care recipients with ZZP4 will not have access to care homes anymore (intramural care is no longer organised). This shift resulted from policy revisions by administrative care offices, which finance long-term care indications (WLZ) (VGZ Zorgkantoor, n.d.). The restriction was based on recommendations from NZa and WOZO and was translated into the principle "Home unless" (Ministry of Health Welfare and Sport, 2022b; NZa, 2023). 'Unless' here means

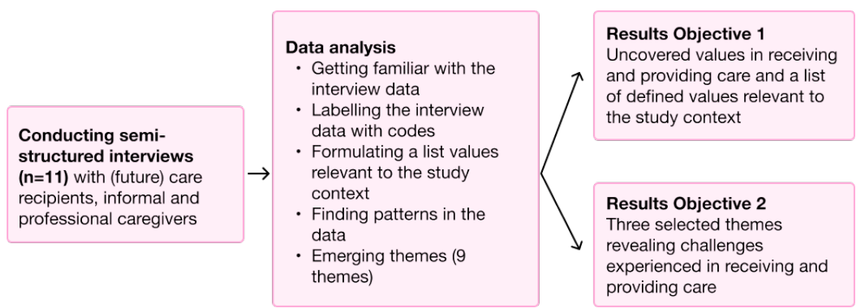


Figure 10, Schematic overview of the research process

there is a need for extra care (if the social context really requires it) or separating living and care: for example, someone can rent a house and receive care, creating an option of having an extramural place in or near a residential care center.

This group was seen as experts by experience in receiving care and was expected to reveal similar things they find important in receiving care, reflecting the perspectives of future care recipients with a similar severity in complaints. Therefore, they represented the perspective of care recipients in this study.

> Five care recipients, living in the same care home, were contacted through Surplus to ensure that participants meet sample criteria, and all agreed on participation.

Future care recipients are selected, currently living in a lean-to home of one of Surplus' care homes, which means that they decided to move to a smaller place, with good physical access, and close to elderly care facilities. Assuming they already receive some sort of support from family and relatives, they can offer valuable insights into essential values in current and future care within their social circle.

> Three future care recipients (includes one couple) were recruited during a monthly coffee moment at Surplus for inhabitants of lean-to homes.

As for representing the perspective of providing care, professional caregivers of Surplus, who are in direct contact with care recipients are selected, as well as informal caregivers are selected.

> One informal carer (verzorgende IG en wijkverpleegkundige) and two professional caregivers showed their willingness for participation via email after a call on the Surplus' employee platform and the third professional caregiver was contacted in person (oud verzorgende IG, nu welzijnsmedewerker)

Table 2 shows participants details. To maintain confidentiality, pseudonyms were used instead of real names. To ensure a representable participant group for Surplus, all participants were either current clients or employees of Surplus, or were affiliated through lean-to homes or informal carer meetings. The sample size was determined based on the timeframe of this first research phase of this project and data saturation, with transcripts investigated until no very new topics were identified (Glaser, 1965).

Following Delft University of Technology Human Research Ethics Committee approval, data was collected of 11 participants in total via face to face or digitally and participants were interviewed in their homes or at work (face to face: all care recipients and two professional caregiver, digitally: one professional caregiver and one informal carer).

The decision to conduct interviews in their familiar settings was aimed at making participants feel comfortable, minimising distractions, and enable a better understanding of their context. Additionally, to mitigate potential bias, such as power dynamics between the researcher and participants (who included vulnerable elderly individuals) I chose to record the interviews. This allowed me to focus entirely on the participants during our conversation (Kendall & Halliday, 2014).

Before conducting the interviews, I informed the participants about the purpose of the research, potential risks, and confidentiality as well as participants' right to withdraw from the study at any time. Informed consent from was obtained on paper or verbal agreement was obtained for the interviews with current care recipients and for the interviews that were held online via Microsoft Teams.

Table 2, Details of participants

Group	Participant	Gender	Age	Current job
1	Professional caregiver 1 (CG1)	f	31-40	Caregiver IG
	Professional caregiver 2 (CG2)	f	21-30	District nurse
	Professional caregiver 3 (CG3)	f	21-30	Caregiver IG/Well-being worker
	Informal carer 1 (IC1)	f	70-80	Informal caregiver/employee at Surplus
2	Care recipient 1 (CR1)	f	81-90	-
	Care recipient 2 (CR2)	f	91-100	-
	Care recipient 3 (CR3)	f	71-80	-
	Care recipient 4 (CR4)	f	81-90	-
	Care recipient 5 (CR5)	m	71-80	-
3	Future care recipient 1 (FCR1)	f & m	71-80	Volunteers
	Future care recipient 2 (FCR2)	f	81-90	-

3.3.2 Interviews

The semi-structured interviews were conducted between 17th of October and 6th of November 2023. I used the interview guide as guiding through the interview, allowing flexibility in order and way of question the prepared questions. Inspired by the NADI-model, a four-layered model focusing on human Needs and Aspirations (Figure 11), the questions were designed to probe and get the deepest level of participants' insights (van der Bijl-Brouwer, 2017). This approach aimed to uncover the underlying reasons behind participants' desires or needs in care scenarios, helping to reveal their values.

Table 3 presents an overview of the interview setup for each group, with further elaboration provided in Appendix 1 alongside the full interview guides. Although the interviews shared a consistent structure, there were slight variations tailored to each participant group. The format for both care recipients, professional caregivers and informal carer was almost the same, except those discussions with professional caregivers involved their experience in collaboration with colleagues and the organisation. And discussions with informal carers focussed on the impact providing care on their personal lives. For the interviews with future care recipients, I applied a slightly different approach; as they do not regularly experience support with personal care tasks like going to bed, I focused on their current relationships during the interviews.

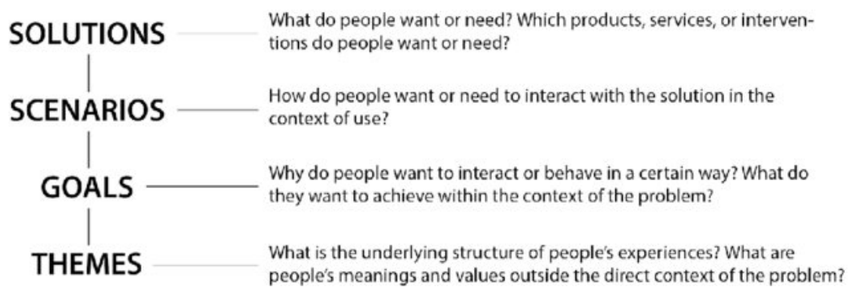
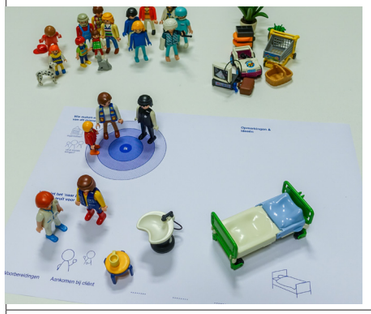


Figure 11, The NADI model: four layers of human Needs and Aspirations for a Design and Innovation process, by Mieke van der Bijl-Brouwer (2017)

Table 3, Overview of interview setups for participant groups

(informal) Caregivers	Care recipients	Future care recipient
0. Before interview: Explaining the project and going through consent form.	**0. Before interview:** Explaining the project and going through consent form.	**0. Before interview:** Explaining the project and going through consent form.
1. General: Establishing connection and comfort through getting acquainted. Focus: Caregiver's Job position, their motivation and what they like about work. (For informal carer the focus lays on their journey to their current care role)	**1. General:** Establishing connection and comfort through getting acquainted Focus: Background of the care recipient, their journey to the care home and their current dependence on care	**1. General:** Establishing connection and comfort through getting acquainted
2. Zoom in: Exploring values in the context of going to bed (or another daily interaction between caregiver picked and care recipient picked by the participant) **Instrument:** Playmobil and scenario outline on paper 	**2. Zoom in:** Exploring values in the context of going to bed (or another daily interaction between care recipient and caregiver picked by the participant) **Instrument:** Playmobil and scenario outline on paper 	**2. Creating a relation map of the social network** **Aim:** Identifying relationships of the participant, to gain insight in who might play a role in caregiving in a later stage and to refer to throughout the interview. To in the end uncover a link between relationships and values. **Instrument:** Blank A3 for relation map, post-its and Playmobile 
3. Imagining a future scenario: Exploring values in one specific daily interaction when care is not available in its current way	**3. Imagining a future scenario:** Exploring values in one specific daily interaction when care is not available in its current way	3. **Imagining a future scenario:** Exploring the dynamics of relationships in the map, which one strengthen or weaken and who takes responsibility
4. Zoom out: Defining the essence of care.	4. Zoom out: Defining the essence of care.	**4. Zoom out:** Defining the essence of care.

3.3.3 Data collection

Interviews were audio-recorded via Microsoft Teams, were conducted in Dutch and lasted 50 to 80 minutes. During the interviews, the ease of uncovering values significant to the participants varied a lot. This was influenced by their varying care needs and reactions to creative tools like Playmobil and relationship maps. For instance, while one participant actively utilised Playmobil to illustrate their bedtime routine, another preferred verbal description, and another did not need assistance with bedtime routines. Consequently, if the bedtime routine was not relevant, we collaboratively selected another care scenario to discuss. Furthermore, insights gained from earlier interviews informed the formulation of deepening questions in subsequent sessions, aiming to confirm and validate emerging patterns.

3.3.4 Data analysis

Getting familiar with the interview data

The audio recordings were automatically transcribed via MS Teams and these were analysed using Thematic Analysis. I started this process during the interviews where I paid full attention to the participant, noting down my thoughts and emotional responses directly after every interview. I further immersed myself in the data by going through the transcripts while highlighting feelings, thoughts, and answers to the interview questions, either directly or indirectly. Simultaneously, I anonymised and improved the transcripts on accuracy (lacking due to speed, volume, or accent, especially noticeable for the interviews with elder participants) so that they retain the information in a way which is 'true' to its original nature. This initial step allowed familiarisation with the data and resulted in a list of initial thoughts on present values and emerging themes, which later fuelled the coding process (Smith et al., 1999).

Getting familiar with the interview data

I then coded each transcript. This involved labelling sections of text (or quotes) that, either semantic or latent, articulate information that potentially indicates values or challenges related to receiving or providing care (Boyatzis, 1998). This information included things participants find important in receiving and providing care, what their motivations are in caring or being independent for example what their perception on care is or where frustrations lay.

To ensure a structured coding process, a codebook was created, based on the first familiarisation with the interview data to encompass the information that potentially indicates values or challenges related to receiving or providing care. These consisted of three code groups: broad values, context, and type. Especially for the code group context and type I used my intuition and iterated during coding to formulate codes which are mutually exclusive and collectively exhaustive. These code groups are further explained below, the full codebook can be found in Appendix 2:

Broad values: The values identified during the initial familiarisation with the data were aligned with Schwartz human values (2012), but refined it values for better applicability to the elderly care context. For example, 'Money' was added to highlight its role in care decision-making, while 'tradition' was replaced by 'dignity' to lay focus on the fundamental importance in care to recognise individuals' worth (mens in de mens zien) and respecting one's tradition became a sub value dignity. This refinement resulted in a customised list of values relevant to this study and included sub-values, definitions, and examples to reduce ambiguity. This list with values is presented in Figure 12, and detailed in Appendix 3.

Context: during care moment, general care-related, organisational, future scenario. It refers to 'when and where', to the setting of a particular parts of the data, which can reveal insights into where identified challenge take place or in which setting specific certain values are more present. These insights are often context dependent.

Type: attitude, example, expectation, frustration, need/preference. This group helps break down 'what' participants talk about, showing the challenges they face (like frustrations) or expectations they have about the future or towards people they interact with, such as between care recipient and professional caregiver. Additionally, 'examples' can help illustrate important values through practicle example.

Labelling text portions rather than individual words allowed for the assignment of multiple codes per piece of text (Figure 13). Which suited with the answers to open-ended or broad questions that covered multiple topics (Campbell et al., 2013). Upon reviewing all transcripts, I conducted a final check on code formulation and potential overlap. Additionally, I worked systematically, to ensure consistent attention was given to each piece of data (Braun & Clarke, 2006).

Emerging themes

Following the coding process, I identified patterns by clustering the labelled data, from which nine themes emerged. These themes captured essential aspects of receiving and providing care, including information on current factors influencing these themes, such as the time pressures faced by professional caregivers (Figure 13). Furthermore, I broke down these themes into the corresponding participant groups to distinguish between themes specific to certain groups and those that were common across groups, see Figure 14 for an example. During the clustering process, I employed both inductive and deductive reasoning. This approach allowed me to uncover new insights and draw inspiration from themes associated with current challenges in elderly care (Patton, 2014). Additionally, the insights labelled with 'type' code group on future scenarios were actively considered in the clustering process, incorporating values at risk due to increasing pressures in elderly care. These were reflected either directly or indirectly in the emerged themes.

Figure 12, List of values adopted in this study, inspired on Schwartz work (2012)

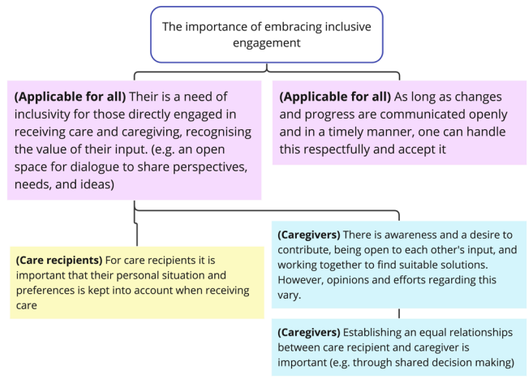


Figure 14. Example of one out of nine themes, broken down into in subthemes represented by various participant groups

Figure 13, Coded text section in ATLAS.ti 23.2.0 for Mac with quote on left and codes on right

3.4 Results

3.4.1 Uncovered values in receiving and providing care

The coding identified 248 different values within the 'broad value' group. This showed a variety of important values important in either receiving or providing care, where they overlap, and how they differ among different participants and contexts.

During the interviews, it became clear that both receiving and providing care are roles that can be fulfilled by multiple individuals and therefore cannot assigned to one participant group. For instance, a professional caregiver shared personal experiences of receiving care, "As a client, I want to be able to say what I need to say. I want to express my challenges, and if I'm stuck somewhere, I want them to see through me" (CG2). Similarly, a future care recipient mentioned offering informal support to neighbours, "No, just a cup of coffee and then it's fine. No, we don't expect anything at all" (FCR1).

Consequently, to distinguish between values associated with receiving and providing care, I focused on the context and role of a participant in that specific part of the conversation, rather than looking solely at their participant group. Apart from some exceptions, values associated with receiving care were primarily mentioned by care recipients and future care recipients (137 codes), while those related to providing care were mostly discussed by professional caregivers and informal carers (112 codes).

It is important to note that findings, derived from qualitative research, cannot be quantitatively measured to determine the significance of certain values. However, they do paint a picture of which values are frequently discussed and which are less so. The distribution of these values is visually represented in the forced directed graph in Figure 15.

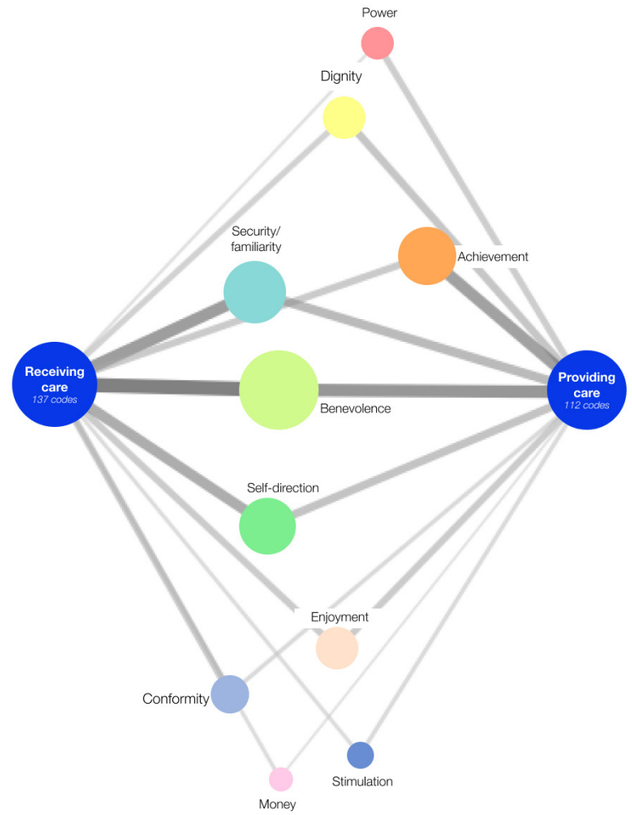


Figure 15, Forced directed graph of coded values in receiving care and providing care

3.4.2 Themes revealing challenges experienced in receiving and providing care

Compared to the results on the divisions of values in receiving and providing care in the previous results, emerging themes provide more insight in the most significant values, areas of overlap, and values under pressure due to increasing demands in care. As such, the code group 'human values' and 'type' (future scenario) helped assess the importance of these values in future contexts where care may be less accessible. The nine emerged themes are listed. For a detailed explanation on these themes, I refer to Appendix 4.

1. A shared desire for prolonged self-reliance
2. Collective desire to maintain meaningful contact
3. The importance of embracing inclusive engagement
4. Mismatch in expectations in the search to care differently
5. (Not) asking for help: the strengths and pitfalls of benevolence
6. Seeing the person within remains crucial in care
7. Seeking mutual support among colleagues and within the organisation
8. Stereotypes surrounding professional carers become more negative
9. Comfort of familiar environments and established routines

3.4.3 Three opportunity areas

From nine initial themes, three were selected for focus. Projecting future scenarios onto these themes helped identify which would become increasingly important due to growing pressures on professional caregivers, the expanded role of informal carers, and the necessity for care recipients to stay home and remain self-reliance as long as possible. In collaboration with my client, we determined which themes had the most significant potential for design based on their relevance, the challenges and possibilities within Surplus, and my intuition and insights from interview data and knowledge of elderly care dynamics (Ch.2). The selected themes, also opportunity areas for the design phase are: Collective desire to maintain meaningful contact; (Not) asking for help: the strengths and pitfalls of benevolence; Mismatch in expectations in the search to care differently. These are elaborated on below.

! **This sign points out the insights that responded to the growing pressures in elderly care.**

Collective desire to maintain meaningful contact

One of the most valued interactions for both care recipients and caregivers is a moment of contact, reflected in human value 'enjoyment'. For care recipients, even a brief moment of emotional attention brings warmth and joy, and a sense of belonging, acting as a shield against loneliness. For care givers it is crucial to be able to balance intense caregiving moments with a light-hearted conversation, laughter, and emotional connection with the care recipient. Additionally, the way a care giver can create space for care recipient to share their personal story, gives them a sense of purpose. Thus despite, the role division of receiving and caregiving, the need for an emotional connection is universal for both groups.

> *"What I enjoy about my job is the contact with the residents, and a bit of gratitude from the people themselves when you do something right." (CG3)*

> *"Interaction with the nurses is very important, which is very pleasant, we can have such a good laugh. But yes it's only short, because they are busy, they are so busy" (CR1)*

! Due to shortage in professional caregivers and the increase in care recipients with heavier care demands, due to policy changes, the caregivers need to cope with more demanding care recipients in less time. This leads to overlooking those who are more self-reliant and makes meaningful conversations become scarce. Consequently, care recipients said to be more hesitant to start a conversation due to the increasing hastiness of caregivers, feeling that seeking a chat is less important than assisting more dependent elderly with physical care needs.

> *"I notice that some people get more attention, and we lose sight of the ones who are still more independent. That's at the expense of those who also have a right to our attention, to our care" (CG1)*

> *"Look, sometimes I do think, but I don't ask for it because I don't want to. But for instance, in the evening when I'm sitting here for a long time, I'm alone. Then I think, it would be nice if someone just popped their head around the door, but I guess they don't have time for that, and I don't say anything about it. And I also don't feel like seeing everyone, I'll be honest about that." (CR1)*

(Not) asking for help: the strengths and pitfalls of benevolence

Caring is often seen as a unidirectional act from caregiver to care recipient in response to an incident or on request from the recipient. However, it appears that care recipients care about the well-being of their caregivers as much as they do for them, as such, the pressure among caregivers does not get unnoticed. This mutual consideration, driven by empathy and understanding (benevolence), can lead to challenges such as reluctance to ask for help and difficulty in setting boundaries. As such, the determination to care for others overshadowing one's own well-being'. Whereas the professional caregivers said to often pass physical boundaries, the informal carers experience many difficulties in setting boundaries, mainly due to the unclear boundary between caring for and acting from love.

> *As informal carer, you're constantly pushing those boundaries, each time just a tiny bit. And in the end, it comes to the point where you say, 'Well, this really isn't working anymore.' And it wasn't because of an incident or anything, but it was just too much (IC1)*

Care recipients may avoid seeking help or company from others, fearing they might inconvenience others, conforming to social expectations (conformity). This modesty among the elderly and their children may be a familiar dynamic, timeless in its nature. Interviews reveal a discrepancy in expectations: while some care recipients feel their family are reluctant to provide constant support, their family insist on care recipients asking for help.

> *"She doesn't have children, which means she has more time for me. The others do have children, and then it's more difficult. You can't just spend all your time with your mother, and by the way, I don't want that at all, for the children to adjust their lives to fit mine. They have their own lives. And, that's how it should stay." (FCR2)*

! With the current pressures, this modesty is increasingly present among care recipients and future care recipients towards professional caregivers. As care recipients increasingly notice the stress and hastiness of caregivers, they become more hesitant to seek assistance, have a chat, and can feel burdened to ask for help.

Mismatch in expectations in the search to care differently

Expectations in healthcare vary among care recipients, but generally, especially with the increasing pressure in elderly care, there is a sense of responsibility to remain independent for as long as possible. As such, in relation to the elderly care system in general, care recipients do not anticipate much but expect care to be readily available when it is genuinely necessary. However, most care recipients do expect caregiver staff to be evidently experienced and knowledgeable when care is needed.

> *"I think that if you can do it yourself, you should. But when it's really needed and you call someone, then you should also get that help." (CR4)*

> *"Where should you ask for help? I have no idea, right? What are the possibilities? What can you expect from the care or something? Because everyone is already overburdened, and then you don't want to be another nag." (FCR2)*

> *"Because here in the Netherlands, it's always pointing fingers at the government and this and that. You know, you should also take some responsibility yourself. Why always shift it onto others?" (FCR2)*

The current care recipients appear rather thankfull for all support they get then demanding or expecting much of the caregivers. If they do, it is more towards the organisation and government, instead of directly to the professional caregiver. The family and informal carer on the other hand, according to the caregivers, often are more demanding as they expect the caregiver or the care organisation to do the highest possible. However, still varies among individuals:

"Yes, but the health insurance law is free for people. So, you must provide me care, because I have a right to it." (CG2)

"And nowadays, because then my sister says: as long as we get help, because there is so little staff, it's getting less and less. I don't know either, she says, so you're actually quite lucky." (CR4)

! Among professional caregivers, expectations mainly stem from the organisation and colleagues. The pressure to deliver quality care in a short time, show authority and stimulate self-reliance among care recipients. Disagreements over approaches often arise among colleagues from differences in educational background or years of experience among caregivers. Caregivers desire for more appreciation from the organisation and for more respect and dignity from the family of the care recipient because they often bear the brunt of changes in care due to increasing pressure. Additionally, despite caregivers being aware of the importance of encouraging care recipients to do as much as possible on their own, tasks are sometimes taken over by healthcare providers for the sake of efficiency.

"But it's constantly being said, yes, you need to show your authority, you need to show your authority, and it's the same story with the client. We are the ones who are always told, 'Yes, but you have that contact with the client, so you must do it.' And the cultural change that we need to go through in the whole of the Netherlands, well, that's just dumped on our shoulders, and that's not fair, and we can't carry it like this." (CG2)

"Out of convenience too, which saves time. So, I'll give a simple example. If a resident can wash themselves at the front, you might say, 'Oh, let me do that for you, because it saves time, allowing you to move on to another resident quicker.' Because that one resident might take, say, 10 minutes to wash themselves thoroughly, whereas you can do it in, for example, 3 minutes" (CG3)

3.5 Conclusion

In conclusion, key values in receiving and providing care were identified, as well as their dynamics under the increasing pressures in elderly care **(objective 1).** This analysis revealed a significant overlap in values between those receiving and providing care, indicating that at the level of values, there's no clear-cut division between the roles of caregiver and care recipient. Additionally, specific challenges were highlighted for both care receivers and the ones providing care **(objective 2).** From these insights, three focus themes emerged, representing opportunity areas which will be projected onto the elderly care system in the next chapter to identify leverage points where the identified challenges can be addressed. The opportunity areas are incorporated into the Frame of Reference, illustrated in Figure 16.

> So far, we addressed project goal 1, namely 'Identify and address values related to elderly care and minimise potential conflicts during the shift to greater autonomy and responsibility for elderly and their social network.'

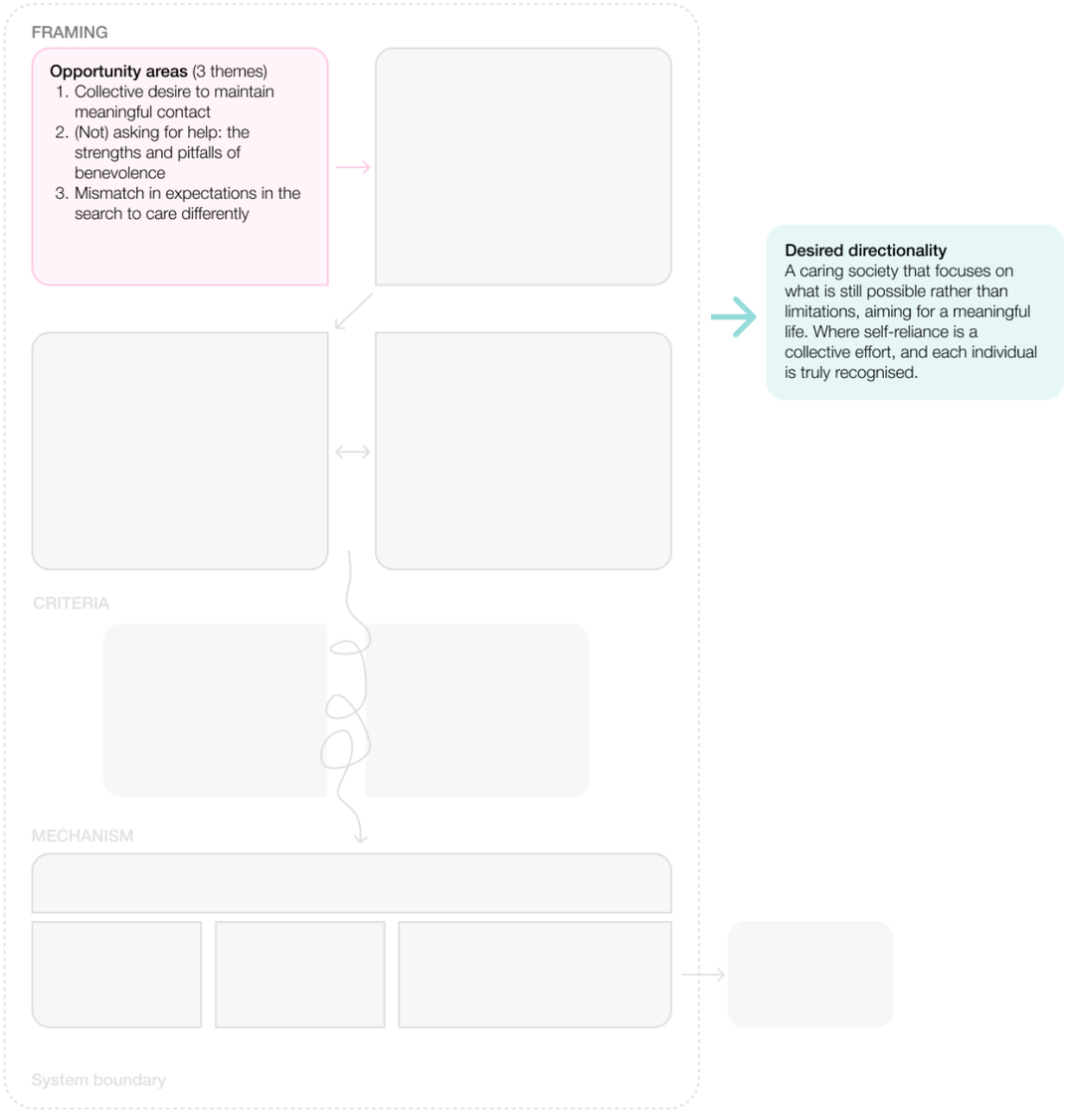


Figure 16, Updated Frame of Reference

04

Chapter 4

Seizing opportunities to intervene

From this chapter and on, the aim is to achieve project goal 2 ‘Design an intervention that consciously incorporates values identified under the previous study, assisting Surplus in guiding the shift to a new care standard.’.

In this chapter the elderly care system is mapped, looking into key actors and their interrelations, refining system boundaries and identifying leverage points within the system, building upon the opportunity areas from Chapter 3. The aim is to refine Project Goal 2 into a design statement that specifies the intended outcomes, target audience, and design context, based on the data previously gathered. This provides clarity on the purpose of the to-be-designed intervention within Surplus’ spheres of influence, serving as a starting point for the creation of intervention concepts.

4 | Seizing opportunities to interrvene

4.1 Towards a desired design statement

After fully immersing myself in the data of sub-study one and the evolved themes, I zoomed out and teamed up with my fellow design students to gain fresh perspectives on my topic and generate initial ideas within the selected themes, see Figure 17. These initial ideas were linked to opportunity areas identified in Chapter 3. Consequently, I formulated 'How to' questions to navigate the solution space. It is important to note that these 'How to' questions do not encompass all methods for addressing the opportunities identified but are intended to facilitate targeted brainstorming on possible solutions.

- **Collective desire to maintain meaningful contact:** How to prioritise and safeguard meaningful contact between care recipient and professional caregiver, to ensure it remains a core component of care?
- **(Not) asking for help: the strengths and pitfalls of benevolence**: How to enhance positive aspects of benevolence in care while directly addressing and mitigating its pitfalls?
- **Mismatch in expectations due to pressure to care differently**: How to proactively manage expectations among elderly care stakeholders, helping professional caregivers, informal carers and care recipients align their expectations for a smoother transition to new care?

Figure 17, Creative brainstorm with fellow students on concepts for the How To's?

To come up with a clear design statement, I used the ViP method by Hekkert and Van Dijk (2011), adding my own twist to tailor it to this study. This process involved defining the context of the intervention by bringing together the selected themes, client preferences, my intuition and take on the study context into a design statement. This statement defines the raison d'être of the final intervention, or the vision underlying the intervention (Hekkert & Van Dijk, 2011). In defining the context, I explored opportunities within the Surplus' sphere of influence in order to increase feasibility and viability. This strategic step aligns with the shared ambitions of both the client and myself. We aspired to develop something with the potential for short-term implementation making it readily available for practical use. Additionally, an opportunity popped up to integrate with an ongoing Surplus project due to our shared objectives.

4.1.1 Defining the context of the intervention: Exploring opportunities within the sphere of influence of Surplus

This involved exploring the possibilities for Surplus to address the opportunity areas.

In order to determine the Surplus' sphere of influence, first the elderly care system was mapped to understand the role of Surplus on their relationships with other actors present in the elderly system. The system map is depicted in Figure 18. Note that not all actors active in elderly care are included, as the focus lays on Surplus' role. Mainly their employees and other relevant parties they are in contact with are included. Subsequently, system boundaries were defined to create focus so that designing becomes possible for a manageable piece of a larger system. Which aided the identification of potential leverage points within those boundaries. As defined by Meadows Leverage points 'are places within a complex system (a corporation, an economy, a living body, a city, an ecosystem) where a small shift in one thing can produce big changes in everything.' (p.3, 1999) . Think of the first domino piece that, once toppled, sets off a chain reaction, causing the rest to move. In this context, the leverage point aims to make the system start moving towards the directionality as stated in section 2.3, namely:

> **Desired directionality**
> A caring society that focuses on what is still possible rather than limitations, aiming for a meaningful life. Where self-reliance is a collective effort, and each individual is truly recognised.

The system map was divided into four categories based on the type of influence within the system: **'strategic,' 'indicative,' 'execution,'** and **'other.'** The strategic category involved actors who had direct influence at the decision-making level, such as directors, managers, and team leaders. 'Indicative' refers to those responsible for assessing (future) care recipients. They determined the severity of a care recipient's needs and expressed it through an indication. This indication was decisive for the reimbursement of care-related matters. The 'execution' category involves actors who provide professional care or those active on the frontline in elderly care organisations. 'Others' encompass care recipients and other actors, independent of care organisations.

In collaboration with T. van der Vange, program manager Social Innovation at Surplus, we explored how all actors are connected. Through this reframing process, by categorising actors and mapping out their relationships, we gained a new, broader perspective on the system (Ryan, 2014). This approach helped us to speculate on the systemic impacts of a to-be-designed intervention, working towards the desired directionality. Next, we projected our focus themes onto the system map to spot a starting point to intervene. The three selected themes - Collective desire to maintain meaningful contact; (Not) asking for help: the strengths and pitfalls of benevolence; Mismatch in expectations in the search to care differently, all centre around expectations between care recipients and people who provide care, involve expressing needs and scream for open communication. Acts such as, expressing the importance of maintaining contact for joy, addressing expectations to avoid misunderstandings or post-surprise reactions, and openly communicating the willingness to care for each other and ask for help, can be discussed in initial conversations with Surplus. This conversation finds place in the overlapping area of indication and execution, see Figure 18. In this stage, care recipient and informal carer enter with certain expectations, providing an immediate opportunity to express and align expectations and needs together. This presents an excellent chance to clarify expectations about self-reliance in elderly care for everyone present, ensuring both the client and caregiver understand what is expected of them and what the available possibilities are.

The widely acknowledged and urgent call for elderly to life at home for as long as possible suggests a focus on homecare and domiciliary care (thuisondersteuning). And according to Surplus, the main challenge to align expectations are currently faced in the care division instead of well-being division, so focus on care division is prefered.

→ **Focus on the initial conversation with Surplus, involving actors in homecare and present in the overlapping area between indication and execution.**

Through engaging conversations with various employees at Surplus and attending an informal care meeting, I gathered confirmation for our chosen starting point to intervene. These discussions also provided key considerations for creating such an initial conversation. As such, we decided on what actors should facilitate and attend the initial conversation, namely:

→ **The care recipient**

→ **The informal carer,** who most is closely involved in the care recipient's life and wants to be informed about care options.

→ **The district nurse,** will be guiding the conversations. Not only because they are currently responsible for the intake, but especially for their holistic view, which is likely to ease adopting to new conversation ways which involves looking beyond the direct care request. Additionally, it is increasingly recognised that district nurses play a crucial role in reducing hospital care and better respond to an ageing society (ActiZ, 2024b)

Government

Municipality (there are 18 in total, each with varying policies on assistance and resources)

Surplus 'Well-being' division (mainly public domain)

Surplus 'Care' division

District nurses know what is in council policy. Some choices lie with municipality.

WMO counter or Social district teams (WMO loket of Sociale wijkteams)

Only if it falls under WMO and otherwise through to the municipality. Sometimes this is the job of the district nurse manager.

Health insurance companies (oversees the Health Insurance Act, implemented by the (district) nurse. Eligibility for district nursing is not determined by the municipality but is a guaranteed right in your insurance's basic package)

Care Offices (ensuring those with Wlz indications receive needed care. Linked to the region's largest care insurer, they contract with long-term care providers, with Surplus as a care choice)

CIZ (Centrum Indicatiestelling Zorg. Here you apply for long-term care indication for Wlz. They assess your needs and determine the suitable care profile, specifying the type and level of care required.

Indicative

CAK (receives data from the Care Office, and CAK sends letter to care recipient. The Wlz is calculated and administered by the CAK. Additionally, the CAK calculates and collects the personal contribution)

Care mediator (Zorgbemiddelaar, Mediator between extra and intramural. Once one needs long-term care or is already on the waiting list, care mediator comes to help.)

13 care homes

Care recipient intramural

Social circle of care recipient

Strategic

Supervisory board (Raad van toezicht)

Board of directors (Raad van bestuur)

General practitioner (Huisarts)

District nurse (extramural, wijkverpleegkundige)

Care recipient extramural

Receiving care and other

Hospitals, rehabilitation, temporary stay

Dementia Counsellors (Independent and affiliated with multiple healthcare organisations)

Leisure activities facilities and organisations

Informal carer

Neighbours of care recipient

Future care recipient

Concern staff (strategy & policy; quality & safety; marketing communication & customer service)

Director support services (Directeur ondersteunende diensten)

Manager HRM

Transfer nurse

Nurse & assistant nurse (Verpleger & verzorgende, intramuraal & thuiszorg)

Family of care recipient

Regional managers intramural

Managers guidance & treatment

Regional managers homecare

Managers well-being

Evolving relationship: When the request is not health related, care recipient is referred to well-being division and WMO

Homeguidance and home support (Thuisbegeleiding, thuisondersteuning)

First Responsible Caregiver (EVV'er, one who has contact with family & caregivers)

Huis van de Wijk & Meeting points

71 operational managers (mix of homecare and intramural care)

Well-being workers (Welzijnsmedewerker, dagbesteding)

Pilot collaboration

Executive

Team managers facility

Volunteers

Practitioners

(can be accessed through Surplus, but also through external parties via the GP. In homecare, the GP is responsible)

Pschycologists

Client council (Cliëntenraad)

Social worker

Speech therapists

Occupational therapists (Ergotherapeuten)

Physiotherapists

Spiritual caregivers

Volunteers

Geriatric specialists (Specialisten ouderengeneeskune)

Dieticians (dietisten)

Figure 18, System map of elderly care, the orange actors are part of Surplus

Integration with an ongoing project “Intake 2.0”

Due to overlapping goals in my focus and a new project within Surplus, we established connections between the two and ensure close collaboration. The project, ‘Intake 2.0’, involves a project team with a project manager, district nurses, and a developer. Its aim is to revise the current home care intake process in line with IZA’s objectives, highlighting appropriate care (self if possible, digital if possible, doing what is needed, shifting care). Stemming from district nurses’ initiative, the idea emerged to collectively develop an Intake 2.0 and train colleagues accordingly. It’s expected that by jointly revising the current intake process, a more holistic approach to deploying appropriate care will be achieved (IZA projectaanvraag 2023).

My role in this project was to inspire the project team and provide a foundation for post-graduation development. The project’s framework provides design guidelines aligned with IZA’s objectives, focusing on appropriate care and reablement. I’ll use these as prerequisites to enhance support and effectiveness from senior management for the implementation of the intervention.

Throughout this thesis, I refer to designing the initial conversation as replacing the current home care intake process, rather than naming it Intake 2.0. While “intake” suggests a one-way process of gathering information from the care recipient, the move towards a shared responsibility suits the use of “initial conversation”, emphasising a more equitable nature of the dialogue.

Concluding: Redesigning intake in homecare within system boundaries

The identified leverage point for the intervention within Surplus’ sphere of influence involved actors engaged in both indicating and executing tasks in homecare. **I seized the opportunity to replace the current intake process in home care with a new type of initial conversation in the intervention design. The participants of this conversation are the care recipient, their informal carer and a district nurse.** The focus on these actors means that I am seeking opportunities for the intervention design within existing roles within the system, for the short term. This defines **the system boundaries** of my project. In the long run, this approach could potentially lead to the creation of new roles. Thus, the leverage point, the initial conversation in home care, within its system boundaries, emerged as a small step forward, moving towards the desired directionality, accompanied by a broad range of other necessary systems change actions (van der Bijl-Brouwer, 2023). The leverage point and system boundaries are added to the Frame of Reference in figure 19.

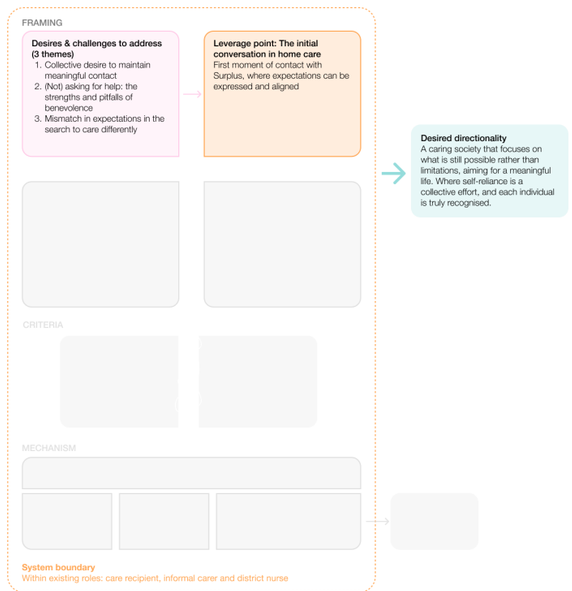


Figure 19, Updated Frame of Reference

4.2 Design statement

Now that the context and involved actors are defined based on the clustered themes and conversations, I formulated the design statement. This design statement is context-based and is supposed to be neither too generic nor too specific, opening opportunity for designing interventions.

An analogy is added to verbally and visually express what I aim to achieve with the design statement. This analogy paints a picture of the relationship between the user and the intervention, without knowing what will be designed (Hekkert & Van Dijk, 2011). The analogy simultaneously describes the needs and desires of the actors interacting with the intervention, together with the intervention qualities which are formulated into subgoals, aiming to embody the desired effect as formulated in my statement.

“My goal is to support Surplus in fostering sustainable collective self-reliance through a value-based initial conversation between care recipient, their informal carer(s) and Surplus. This involves creating an adaptable overview of the care recipient’s unique situation.”

Design Statement

Explanation of statement

In the context of elderly care, public plans often emphasise self-reliance, defined as ‘the quality of not needing help or support from other people (Cambridge Dictionary, 2023).’ In my design statement, I expand this self-reliance from the individual towards being a shared effort, by adding collective self-reliance (“samenredzaamheid’). Herein the elder care recipient and the people or other resources (e.g. healthcare technology or daily activities) surrounding them collectively work towards minimising the need for professional care. Supported by Actiz, self-reliance necessitates working together, making it inherently linked to ‘collective self-reliance’ (2013). While no distinct English definition exists for this term in a care context, Dutch offers various interpretations for ‘samenredzaamheid’ in elderly care. This study adopts the following definition: “people’s ability to get by as much as possible with the help of friends, neighbours, family and volunteers” (Zorg voor Beter, 2023).

However, relying solely on informal carers is insufficient to cope with all care burdens and potential medical incidents. Therefore, I believe that this intervention must support professionals such as Surplus to participate in collective self-reliance.

To define ‘value-based conversation’ I adopt the description provided by Jan Kremer, professor of healthcare and society and special envoy (“speciaal gezant Passende zorg”) for appropriate care (personal communication, March 18, 2024). He describes a value-based conversation as one focused on leading a meaningful life, regardless of one’s life phase, keeping in mind what matters most to an individual with every decision made. For instance, in the healthcare context for some elderly, the focus might not be on curing their illness but on how they can still lead a meaningful life with the people around them. Values like autonomy, solidarity, or finding purpose can be crucial, enabling individuals to take steps in their lives despite their condition. He describes the role of values as follows: “Values are more considerations that you take with you, a kind of compass that can help you make difficult decisions” (J. Kremer, personal communication, March 18, 2024).

Analogy of a coaching board during team play

The interaction of the intervention can be expressed by the following analogy, depicted in Figure 20: Just like team discussions and pep talks during a hockey match. Expressing expectations, aligning tactics, and sensing a shared goal, often made accessible and tangible through the use of a coach board. When a player has a suggestion, the coach hands over the whiteboard marker, allowing them to make adjustments on the coach board. Throughout the game, it is crucial to trust each individual and their team efforts, aiming for what is achievable. There exists a freedom to experiment and learn from failures during subsequent breaks, fostering a dynamic attitude and flexibility to adjust for everyone involved. These moments provide a collective overview of expectations and guidelines for moving forward.

In our context, the intervention represents the coach board and Surplus the coach of the team (care recipient and informal carer). Surplus is the facilitator and motivator who inspires **confidence** among the team and who has an overview of all players and understand how they can interact effectively. Their role involves conveying this **understanding** to all team members, ensuring awareness of each other's capabilities and expectations to foster collective self-reliance. Following from the analogy, intervention qualities (sub-goals) are formulated as a way to achieve the design statement. The highlighted text in the analogy description corresponds to the titles of the sub-goals.

Intervention qualities

Dynamic: The design intervention should be dynamic, allowing adaption to changing needs and circumstances of the care recipient, informal carer(s) and other recourses. This long-term support aims to contribute to sustainable collective self-reliance.

Accessible: The design intervention should be accessible for the care recipient and informal carer, enabling participants to consult it post-conversation and be able to use it to communicate about their situation with others in their surroundings.

Confidence: The design intervention should enable care recipients and their informal carer(s) to feel confident and knowledgeable to start fostering collective self-reliance after the initial conversation with Surplus.

Understanding & Trust: The design intervention should facilitate mutual understanding and trust among all attendees, ensuring that the outcome resonates with and addresses the unique situation of each care recipient.

Figure 20, Team discusses tactics during field hockey break, photo by Ianthe van Alkemade

The design statement and intervention qualities have been incorporated into the Frame of Reference, as illustrated in Figure 21. These will be consulted in the subsequent chapter, where mechanisms will be explored to realise the desired intervention qualities and achieve the design statement.

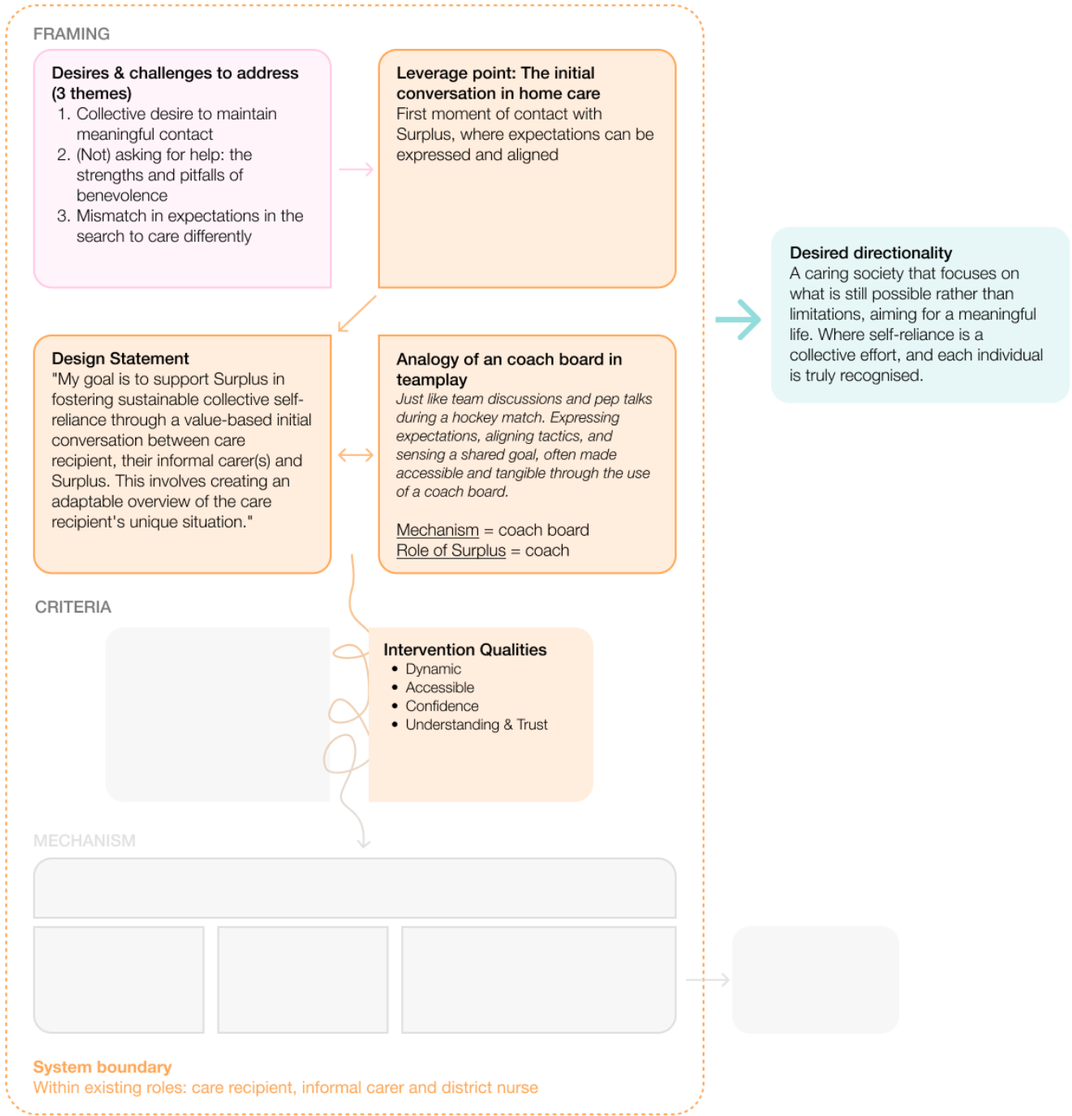


Figure 21, Updated Frame of Reference

05

Chapter 5

Creating the intervention: desiging a value-based intial conversation in home care

This chapter outlines the journey to designing the final intervention, aiming to achieve the design statement set out in Chapter 4, while also considering the additional elements within the frame of reference depicted in Figure 21. It starts with an analysis of the current initial conversations at Surplus, followed by an exploration of existing tools designed to foster collective self-reliance and employ value-based approaches. Through an iterative process of prototyping interventions and integrating new insights, the frame of reference is refined to specify the criteria for the final intervention.

5 | Creating the intervention: desiging a value-based intial conversation in home care

5.1 Exploration of interventions to achieve the design statement

I entered the design phase with three key questions: ***How does the current intake process work and what can be improved? How can we design value-based conversations? How can we motivate people to become more collective self-reliant?*** Through discussions with employees at Surplus and elderly and through reviewing examples of tools and initiatives promoting value-driven conversations and self-reliance, these questions were addressed and inspiration was collected to fuel the development of intervention concepts and design requirements. The key insights of the design activities together with the design requirements are discussed below. See Figure 22 to get a feeling of the various design activities, and for more detail on each design step, I refer to Appendix 5.

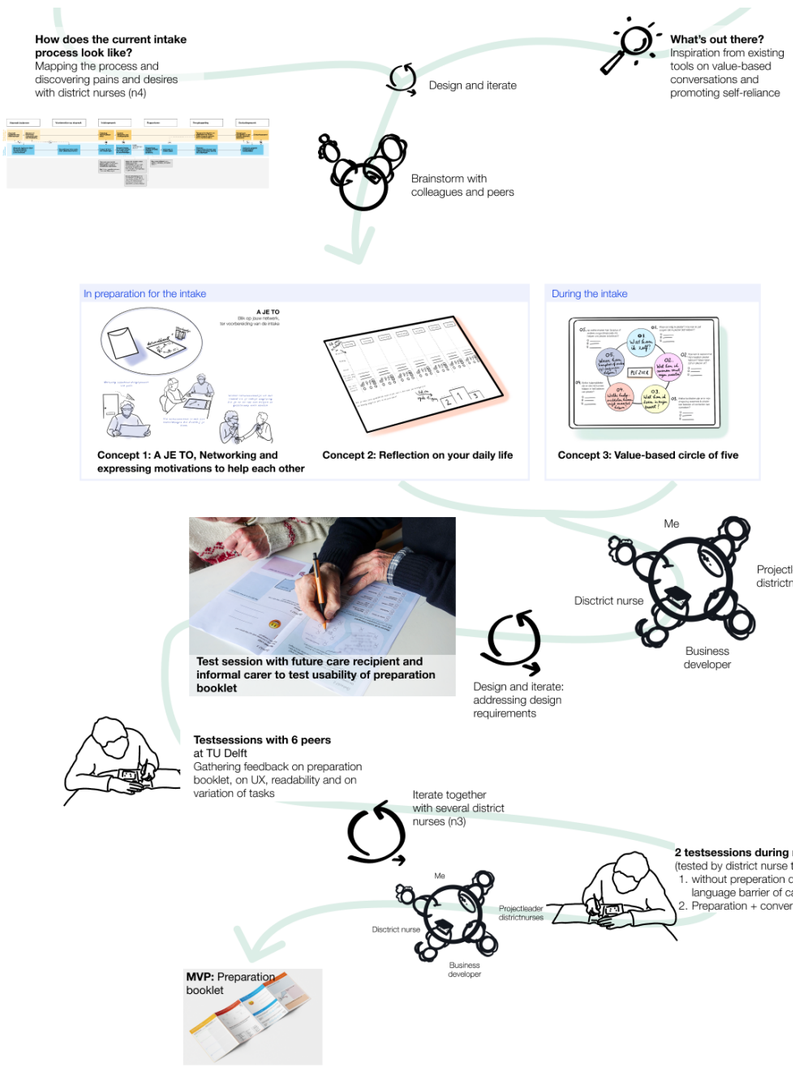


Figure 22, overview of design activities from start to creation of a MVP

5.1.1 Key insights

→ *Underlined text highilights a design challenge, to be addressed in the creation of the intervention*

Current intake process and room for improvements
(insights derived from several meetings with four different district nurses of Surplus)

Several district nurses noted the absence of a uniform way to do an intake, each adopting their own method. Various conversation guidelines exist, such as the holistic approach Gordon health patterns, which nurses are familiar with from education, or the SFMPC, a list of problems which vulnerable elderly could face. Some district nurses utilise the information requested in reporting as a basis for their conversations and where one relies on memory the other uses physical lists during intakes (Figure 23). While a district nurse does ask for deepening questions and aims to look beyond the care questions, their focus is primarily on gathering information rather than collaborating on plans to promote self-reliance or creating a tangible overview . Additionally, the extent to which these guidelines are used varies significantly among nurses, which can create challenges when training new staff or introducing trainees to the process. As well by the district nurses themselves as by the management team in homecare there is a desire for as more uniform way of working (derived from a conversation with two district nurses and a meeting with Surplus' Manager home care and District nurse manager, 2023). Especially with the urgency to adapt a more holistic approach, which requires new methods for among other things, the intake process, they are looking for usable instruments that suit the skills of the district nurse and the ambition to encourage self-reliance of the care recipients and their social circle.

In contrast, when it comes to reporting intake data, there is a more uniform approach. Surplus, together with around 80% of district nurses in the Netherlands (Zorg voor Beter, 2023b), uses the Omaha System. This is a classification system for healthcare professionals to document care recipients' health status, actions, and outcomes. However, this system is oriented toward caregivers, with its terminology and categories often too complex for care recipients and informal carers to understand. Some nurses prefer using their laptop to report during the intake, while write prefer handwritten notes as they find this more personal during the conversation. Reports are then uploaded to Caren Zorgt, an online client portal that informal carers utilise, while care recipients themselves seldom use it. In discussions with four district nurses, we have explored the minimum information that is needed to collect during an intake for Surplus to be able to initiate necessary care, included in the design requirements (Ch.5.2). An overview of the current intake process is depicted in Figure 24.

Regarding the current relationship between district nurse and care recipient, it appears that district nurses, adopts a solution-focused

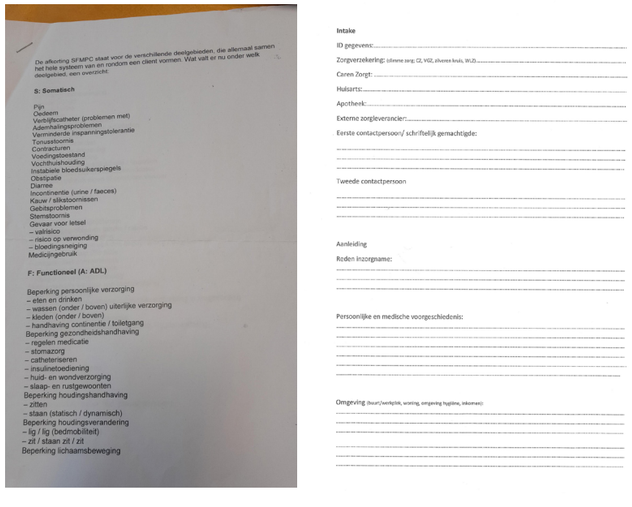


Figure 23, Example of current intake materials for guiding the conversation and reporting

approach. While they think holistically and strive to find fitting solutions, once the visit is over, often solutions are initiated without direct visibility or involvement from the care recipient and their informal caregiver. This means the control primarily remains with Surplus. As seen in Figure 24, feedback between the district nurse and care recipient is not standard in the intake process until the evaluation conversation, although in practice it varies per district nurse in how they keep in touch with their clients. This solution-focused interaction offers opportunities for a more coaching-oriented role where the district nurse observes and advises rather than directly solving problems, empowering care recipients and informal caregivers to manage more themselves.

Moreover, there is a tendency for some care recipients, particularly their informal caregivers, to enter the intake conversation with specific expectations tied to a specific care question. Some are not afraid to accentuate this hoping to receive the help they desire (as observed by district nurses). The challenge is in managing these expectations, clarifying that Surplus adopts a broader view beyond the immediate care question, highlighting the importance for a collaborative effort.

Current tools for value-based conversations and for fostering collective self-reliance

Given the multi-interpretable and abstract nature of values, I avoid using the word 'value' in creating a value-based conversation. Instead, I focus on uncovering what truly matters (most) to the client and their informal carer, both now and in the future. Insights from initial interviews, and inspiration from healthcare tools helped to create relevant and understandable questions for this study context and the initial conversation. Several overarching organisations in elderly care, including ActiZ, Movisie, V&VN, Vilans, Waardigheid en Trots, and Zorg voor Beter, actively develop tools and resources to promote new conversational approaches and enhance self-reliance. For instance, the Institute for Positive Health's Conversation Instrument 2.0, focused on discussing what truly matters, by addressing topics such as meaningful life, quality of life, participation and daily life. These topics served as inspiration (Institute for Positive Health, 2021). Methods such as Advanced Care Planning and Reablement, were explored to encourage collective self-reliance and appropriate care. Additionally, methods to map one's social network, such as an ecogram were considered (Zorg voor Beter, 2023a). However, these tools primarily focus on the care recipient or informal carer or serve as guidelines for the professional caregivers, rather than addressing their interaction or the initial conversation moment.

To introduce collective self-reliance into initial conversations, I adopted the Circle of 5, a conversation tool that Surplus is increasingly using and is committed to integrating into its workflow across departments . Originally the 'Wheel of 5' was developed by De Zorgboog (n.d.), and based on WOZO (chapter 2.1). It facilitates collaborative discussions among care recipients, relatives, and caregivers, exploring broader care options. By addressing five key questions, it assesses the client's abilities, potential aids, family/informal carer involvement, social network support, and other local resources before involving healthcare professionals (see Figure 25).

Making care recipients think beyond their care question through sensitisation

Initiating a value-based conversation within a limited timeframe presents challenges, especially when balancing between addressing practical care issues and exploring deep values with care recipients and informal carers. Encouraging care recipients to look beyond their initial care question and consider broader aspects important for long-term self-reliance necessitates in-depth questioning and reflection time. A preparatory exercise could offer a way to prepare for such a conversation. Sensitisation in this context gives care recipients control and space to gather insights into their real-life situations through self-reflective exercises (Stappers et al., 2010). As such, it could help care recipients reflect on what they value in terms of independence or social connections, rather than solely focusing on care needs.

Figure 25, Schijf van Vijf from De Zorgboog (n.d.)

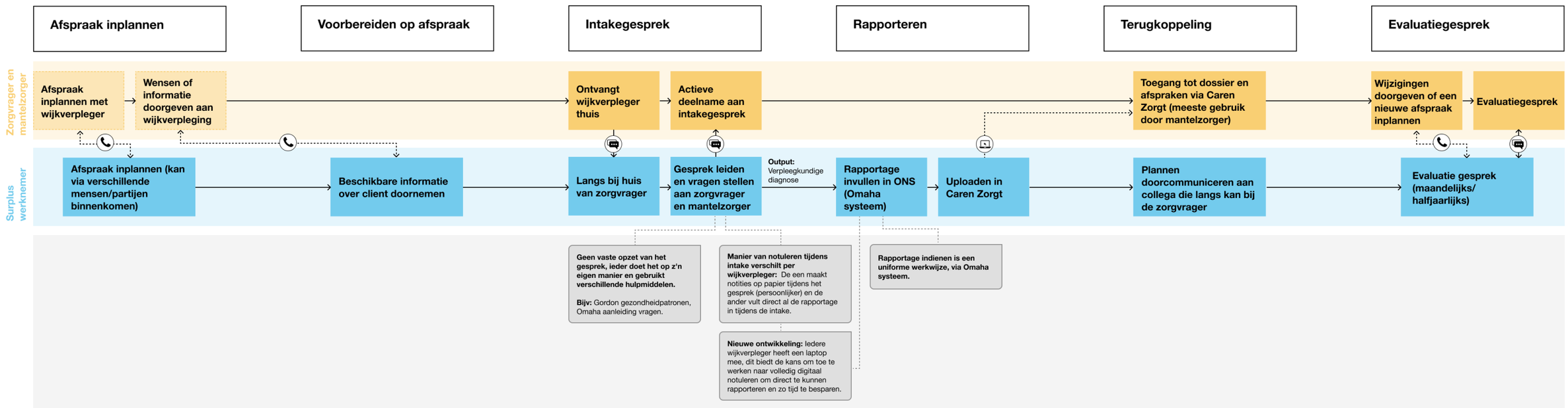


Figure 24, Overview of current intake process

5.1.2 Conclusions and decisions based on key insights

In the exploration phase, various concepts were created and considered. After discussions with the Intake 2.0 project team and including the key insights, we chose to focus on a combination of a preparatory exercise for care recipients and a new initial conversation incorporating the Circle of 5 (Figure 26). For detailed information on these concepts, I refer to Appendix 6. While other concepts leaned more towards the social domain, for example, Surplus actively engaging the care recipient's network, the chosen concepts suit within the care domain and thus remain within scope.

A key recommendation from employees at Surplus, who have experience with innovation projects for the elderly, is for the design of the preparation/sensitisation to avoid asking care recipients to design themselves or avoid giving them too many tasks or decisions to make. It's important to find a balance between giving them freedom and not overwhelming them, especially given their vulnerable state.

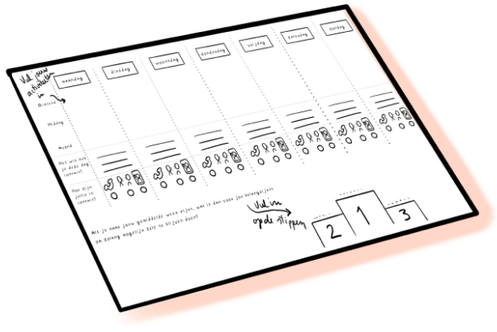
In terms of the usability of the intervention for the district nurses who will conduct the conversation, it is important to develop an intervention that allows for conversational flexibility, encouraging and trusting nurses to use their own conversation skills to look beyond the direct care question, within a well-structured and uniform intake process.

These recommendations are incorporated in the design requirements in section 5.2.

5.2 Design Requirements

Based on the key insights from section 5.1 and the desired input and output of the first concepts (outlined in Appendix 7), I have formulated a set of design requirements. These requirements specify functionalities, capabilities and characteristics essential for the to-be-designed intervention (van de Poel, 2013). These guide the design process and ensure that the intervention meets the needs of the end users and aligns with the objectives of Surplus. Together, the aim is to create a solution that is desirable, feasible, and viable for short-term adoption and integration by Surplus.

If a certain design requirement is intended for a specific user this is indicated by the following abbreviations **C= Care recipient, I= Informal carer, D= District nurse**



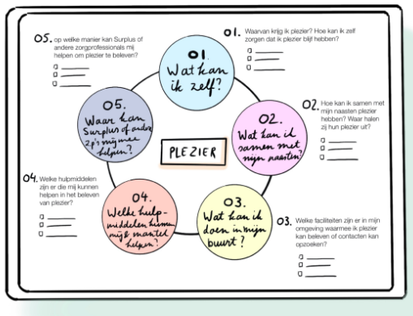


Figure 26, Chosen concepts to develop further, on te left a preparatory exercise for care recipient to map one of their weeks and point out things they find important to do independently. On the right, conversation Framework for initial conversation along the Cirle of 5.

The preparation exercise should…

- (C&I) Encourage users to consider beyond their initial care request.
- (C&I) Provide a clear explanation of the preparation exercise's purpose and its necessity of fully completing the booklet prior to the introductory meeting.
- (C&I) Highlight the importance of informal carers' presence at the introductory meeting.
- (C&I) Clearly define what care recipients and informal carers can expect from the introductory meeting.
- (D) Include questions for collecting personal details necessary for ONS (Omaha System) reporting.
- Enable within 24-hour distribution to care recipient (to accommodate a variety of time between scheduling and date of meeting per care recipient).
- Ensure the exercise can be distributed with one click and sent directly to the care recipient's registered address.

Accessibility of both the preparation exercise and the introductory meeting:

- (C&I) Use simple, understandable language, B1 level.
- (C) Ensure text and visual elements are easily readable, a font size of 12 or larger.
- (I) Offer a hybrid (paper and digital) version of the exercise for informal carers.
- (C&I) Ensure questions and exercises are intuitive and consistent.
- (C&I) Avoid requiring care recipients to design new things themselves.
- (C&I) The completion duration is max 45 minutes for care recipients and 15 minutes for informal carers.

The introductory meeting should…

- (D) Support district nurses in facilitating the conversation.
- (D) Offer a structured framework contributing to a uniform way of working, while allowing district nurses a certain freedom in their way of conducting conversations.
- Ensure instruments used during the meeting are clear to all participants.
- Facilitate the distribution of meeting outcomes to all participants.
- Promote active participation.
- Create the opportunity for participants to openly share and align their expectations.
- Duration of the entire meeting is max 1 hour.
- Support both in-person and video call meetings.

Design, reflect and iterate from concept ideas to MVP

Addressing design requirements together with using inspiration from existing tools and conversational approaches led to refining and combining the two selected concepts from Figure 26 into a Minimal Viable Product (MVP). This design process involved engagement with future care recipients, informal carers, professional caregivers and peers and included user testing during real intakes (for the results of these test sessions I refer to section 7.3 on page 72). In this way the concreteness and usability of the concepts gradually improved, accommodating diverse user preferences. Iterations based on testing and discussions with colleagues led to adjustments in wording, formatting, and question phrasing. All these iteration cycles led to a cohesive Minimal Viable Product (MVP), as explained below. The design requirements and MVP are added to the Frame of Reference in Figure X.

5.3 MVP: preparation booklet + conversation framework

The MVP, including a preparation booklet and conversation framework (detailed in Chapter 6), represents a new approach to the current intake in home care (Figure 27). It lays the foundation for the final intervention, as it encapsulates all questions and topics that should be addressed during both preparation and the conversation itself. It allows for quick testing in practice and its low development costs and easy distribution increase the opportunity for short-term implementation for Surplus.

> The MVP's foundation and the final intervention revolve around the following four topics capturing the care recipient's unique situation: **'Joy,' 'Daily Activities,' 'Contacts' and 'Looking Forward.'** These topics translate complex reporting methods or value-based conversation tools into easily understandable and concrete topics for both care recipients and informal carers, encouraging them to think beyond their immediate care needs.

The final intervention, namely "T-Doos" to be detailed in Chapter 6, builds on the MVP's preparation booklet and conversation framework. It is designed to be more interactive, easily adjustable, engaging, fun, and insightful for care recipients, encouraging deeper reflection on their values and feeling in control of their unique situation. This final intervention emerged from brainstorming and dot-voting ideas that had significant potential to encourage personal control and a sense of responsibility, as briefly shown in Figure 28, and detailed in Appendix 8.

Due to the consistency in questions and topics between the MVP and final intervention, Chapter 6 will clarify these elements. For a comprehensive overview of the MVP, I refer to Appendix 9."

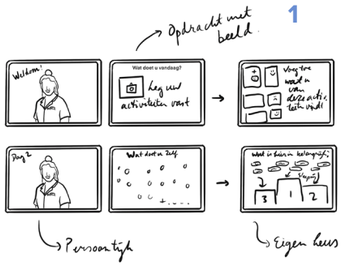


Figure 27, MVP: preparation booklet

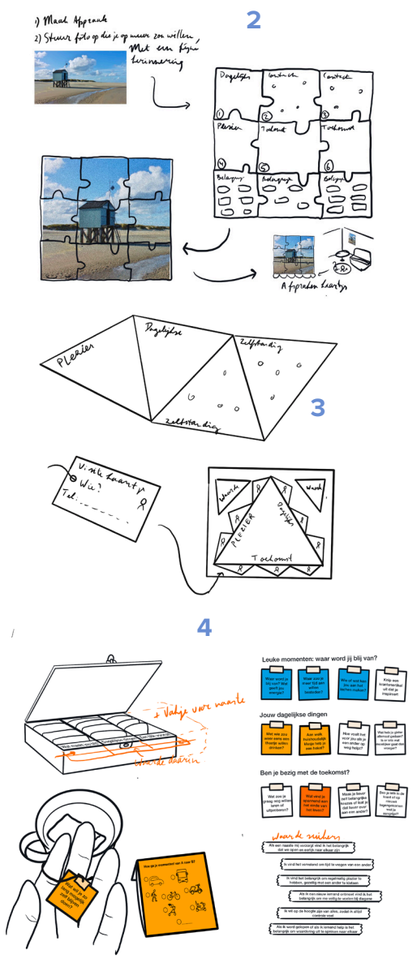


Figure 28, Concept ideas following from iteration on MVP to increase engagement, interaction, fun. The final intervention is based on concept 4.

The revised Frame of Reference is illustrated in Figure 29, which serves as the foundation for the development of the final intervention, introduced in the next Chapter 6.

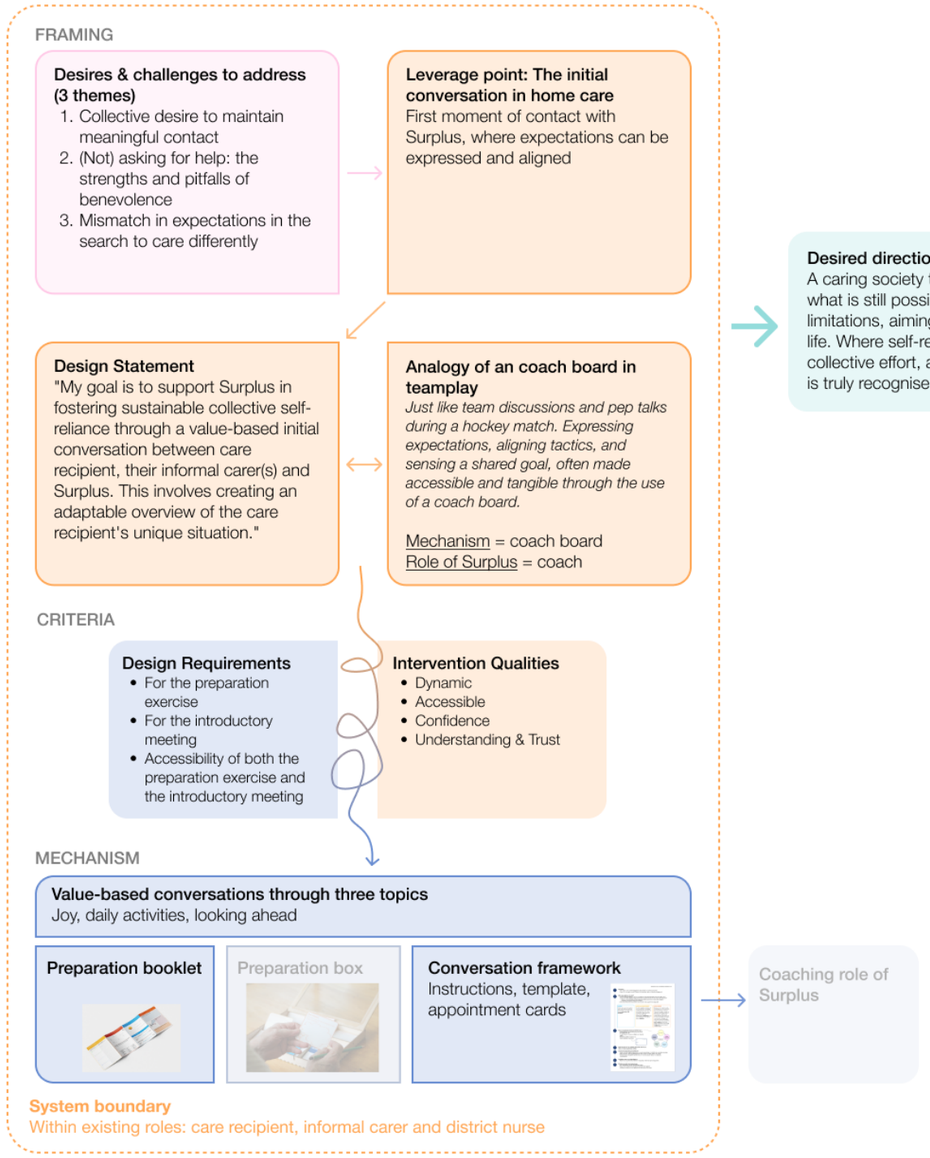


Figure 29, Updated Frame of Reference

Chapter 6

Final intervention:

T-Doos

‘Time for Conversation, Tea for Two, Stay Home Longer’
‘Tijd voor gesprek, Thee voor twee, Langer thuis’

This chapter presents the final intervention the ‘T-Doos’, a new approach to the initial conversation in home care, that aims to make care recipients feel in control of their unique situation. The handing over of the T-Doos is characterised by shared responsibility.

6 | Final intervention: **T-Doos**

The ‘T-Doos’ (T-Box) introduces a new approach to the initial conversation in home care. What used to be an “intake” now becomes an “introductory conversation”. It encourages shared responsibility, moving beyond addressing immediate care needs and focusing instead on possibilities rather than limitations. This intervention aims not just to avoid additional homecare services but to support care recipients and their informal carers in the journey to becoming more collectively self-reliant. It consists of a personal preparation package existing, including the T-Doos (conversation box) and a booklet for the informal carer, paired with a conversation framework for the introductory conversation. T-Doos invites the care recipient to think together with their informal carer(s) about what is important to them in daily life, who they are in contact with, what makes them happy and how they look ahead. This preparation sets the stage for the conversation with the district nurse which is centred around the same four key topics as shown in Figure 30, it aims to understand the care recipient’s unique situation and together explore the possibilities.

Before discussing the details of the T-Doos and the conversation framework, the following scenario illustrates the use of ‘T-Doos prior to the introductory conversation:

Figure 30, Three main topics as foundation of Het Kennismakingsgesprek

Prior to the introductory covnersation

After scheduling an introductory meeting with Surplus, the booklet is sent directly to the care recipient’s home.

Upon reading the instructions, I explore the T-Doos, finding a combination of teabags and question cards.

I pick a card in the catagory ‘contacts’, with the question ‘Who are in your social circle?’ It makes me think who to include and who not.

I write down the people I have regular contact with and what we are from each other.

Flipping the card, my son and I, who often helps me, discuss what’s important in our social interactions.

While making tea, I notice a question on the teabag label related to my social circle.

My son and I ask each other the questions from the labels, sparking an open conversation.

6.1 T-Doos: preparatory package

The preparation package, including the T-Doos, is intended for both care recipient and their informal carer(s). It serves as both a sensitisation tool and a means to gather personal information in advance, fostering a different type of conversation. It is designed to be interactive, easily adjustable and to encourage deeper reflection on personal values. This sensitisation aims to facilitate care recipients to articulate what is important to them, extending beyond their care needs, more effectively during the introductory (Keller et al., 2006).

The T-Doos is a tangible intervention delivered directly to the care recipient's home, symbolising the handover of control and responsibility. It enables rapid distribution and invites personalisation and ongoing engagement throughout their care journey. It contains instructions, tea bags with reflective question labels, and question cards, as illustrated on the right. Figure 31 shows two question cards and the full set of cards are shown in Appendix 10.

Instructions and personal details

The instructions within the T-Doos are designed to explain how the T-Doos works and why this approach and to set clear expectations for the introductory meeting, highlighting the importance of the preparation exercise for care recipients and Surplus. De instructies moeten vertrouwen geven voor de gebruiker dat ze het kunnen invullen end at geen antwoord fout is. Additionally, by requesting personal information typically gathered during intake, the process frees up time during the meeting to focus on planning rather than extensive questioning.

Booklet for informal carer

The booklet for informal carers includes questions to engage them from the start, given the increasing demands on informal carers, their involvement is just as important. It asks them to reflect on what's important for support and any difficulties they face, aiming to prevent overburdening and fostering a supportive and collaborative environment from the start. Through this preparation, Surplus can also get to know the informal carer. During the meeting, the booklet is supposed to help them express their expectations and needs towards both the care recipient and Surplus.

Figure 31, Question cards on joy and daily activities

Question cards

The question cards in the T-Doos promote flexibility because they are separate tickets and have no set order, encouraging users to engage with them at their own pace, which contrasts with the linear progression of a questionnaire. The T-Doos can be revisited multiple days before the meeting, with tea bags offering moments for reflection or discussion on their labels.

Tea bags with question labels

The tea bags within the conversation box feature questions on their labels related to values, acting as a light-hearted deepening tool to encourage self-reflection and discussions. These questions, such as "Who makes you laugh?" or "How does helping others make you feel?", align with the question cards' topics, represented by the tea bags' colors (Surplus' house style colours), which also correspond with Surplus's conversation framework themes for district nurses. (All tea labels can be found in Appendix 10).

Question cards

The question cards in the T-Doos are comprehensive, designed to resonate with users in their language, focusing on everyday life aspects. Aimed at care recipients in a vulnerable state, the questions are well-balanced and categorised by topic, ensuring manageability and readability. The size of the text and word choice are crafted for easy understanding to increase inclusivity.

It's name

The name 'T-Doos', with its subtitle 'Time for Conversation, Tea for Two, Stay Home Longer', encapsulates the intended purpose of the intervention, namely:

Tijd voor Gesprek | Time for Conversation: Preparation ensures that there is more time available during the conversation to make plans.
Thee voor twee | Tea for Two: This is a literal reference to a box containing tea bags and sets the tone that it is something to be used together, promoting the underlying principle of shared responsibility.
Langer Thuis | Stay Home Longer: This refers to fostering collective self-reliance.

6.2 The Conversation Framework

During the introductory meeting facilitated by the district nurse, the conversation framework, consisting of instructions and a fill-in template, is used. The completed question cards from the T-Doos are consulted to collaboratively set personal goals and make plans to across the four topics, aligning with the fill-in template.

The conversation framework consists of instructions for the overall meeting moment and a template for the district nurse to fill in. It is centered around same three topics as behandeld in de preparation box.

The conversation framework, complementing the T-Doos, guides the district nurse through the introductory meeting. It features a set of instructions and a fill-in template focused on the same four main topics introduced in the T-Doos. These are shown in Figure 33-34. Building upon the insights gathered from the T-Doos, that shows ‘what’ is important to the care recipient and informal carer, through the lens of the Circle of 5 approach, as shown in Figure 32, they together explore ‘how’ to achieve personal goals, aiming to enhance joy, alleviate daily challenges, preserve independence, achieve dreams, and cope with fears. The Circle of 5 is flexibly integrated within the framework, allowing for a tailored approach to each topic based on the care recipient and informal carer’s needs. Key decisions and plans are written down in the template and shared with care recipients and informal carers via both Caren Zorgt (digital client file) for immediate digital access and a hard copy for those without digital capabilities. The district nurse utilises this framework to transition from a problem-solving role to a coaching role, encouraging a collaborative exploration of solutions and future planning. This role is detailed further in Section 8.2.

“This new collective approach to the initial conversation changes the starting point, thereby also transforming the organisation’s character. Topics have been made accessible and personal, eliminating the need for a rigid checklist of questions to be asked.”

(van der Vange, T., program manager Social Innovation at Surplus, personal communication, March 19, 2024)

Figure 32, The Circle of 5, inspired by the ‘Schijf van vijf’ by De Zorgboog. (n.d.).

During the introductory covnersation

District nurse introduces the introductory conversation and asks how Mrs and Mr experienced the preparation

District nurse looks into the preparation booklet of the informal carer

District nurse elaborates on Mr’s answers about what makes him happy

Mrs. and Mr., along with the district nurse, collaboratively explore possibilities to alleviate Mr.’s daily challenges, and use an appointment card to note down an appropriate technological aid for assistance.

Tangible engagement

Involves care recipients with physical materials before, during, and after the introductory meeting, enhancing engagement and personalization.

Appointment cards

These cards are designed to capture and document agreements, enabling care recipients and their informal carers to understand and easily retrieve actionable steps. They can be updated with each district nurse visit, contributing to a dynamic and evolving care plan.

Afsprakenkaartje

Wat:

Wie:

Contact:

Flexibility

Offers district nurses the freedom to choose the sequence and depth of information, accommodating additional notes like life history, medication, and emergency measures to cover all essential care initiation details.

GESPREKSTOOL T-DOOS

1 Verwelkom
- Leid in wat er in het kennismakingsgesprek voor bedoelt is en hoe het eruit zal zien
- Vraag of er nog vragen in de lucht hangen om te bespreken tijdens het kennismakingsgesprek

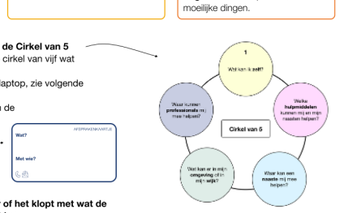
2 Wat is belangrijk voor de client?
- Pak het voorbereidingspakker erbij en kom erachter wat de cliënt belangrijk vindt, waar krijgt de client energie van? Welke dagelijkse dingen kan de client nog zelf? Hoe kijkt de client naar de komende jaren?
  - (Indien de client het boekje niet heeft ingevuld, probeer dan zelf aan de hand van de volgende categorieen persoonlijke doelen te formuleren.)
- Formuleer samen persoonlijke plannen aan de hand van de volgende drie categorieen:

PLEZIER
Ontdek wat de cliënt blij maakt en waar zij/hij energie van krijgt. Stel samen doelen op om deze te fijne dingen te **behouden of te versterken.**

DAGELIJKSE BEZIGHEDEN
Kijk welke dagelijkse activiteiten de cliënt nog zelf kan en wat lastiger is. Blijf positief en leg de nadruk op wat er nog wel kan, i.p.v. van er niet meer kan. Maak samen een plan om de zelfstandige vaardigheden te **versterken** en om met moeilijkheden om te gaan of deze te **verlichten**.

BLIK VOORUIT
Bespreek hoe de cliënt en naaste de toekomst zien. Wat hopen ze te doen of waar kijken ze naar uit? Waar zien ze tegenop of vinden ze spannend? Bied ruimte waarin ze hun angsten en zorgen verder kunnen toelichten. Het doel is niet om deze onmiddellijk op te lossen, maar om aan te moedigen dat deze onderwerpen bespreekbaar worden. Maak samen een plan om **toe te werken** naar de mooie dingen in de toekomst en hoe **om te gaan met** de spannende en moeilijke dingen.

3 Plan van aanpak aan de hand van de Cirkel van 5
- Behandel elk plan en kijk met de cirkel van vijf wat de mogelijkheden zijn.
- Vul de template in via jouw werklaptop, zie volgende pagina.
- Stimuleer de cliënt en naaste om de afsprakenkaartjes te gebruiken.



4 Neem het plan door en controleer of het klopt met wat de cliënt en naaste in gedachten hadden.

5 Vervolg & terugkoppeling persoonlijk plan
- Spreek af wat de volgende stappen zijn en zorg dat verwachtingen nu duidelijk zijn voor iedere aanwezige.
- Leg uit op welke manier het persoonlijke plan door de cliënt en naaste gebruikt kan worden.
- Geef aan dat jullie terugblikken op het boekje en het persoonlijk plan tijdens een halfjaarlijks evaluatiebezoek.

6 Praktische vragen en overige afspraken
- Bedenk of er nog informatie ontbreekt en vraag deze uit (denk aan persoonsgegevens)

7 Afronding en ruimte voor laatste vragen
- Sluit het gesprek af met een optimistische houding.
- Vraag of alles duidelijk is en welk gevoel ze hadden bij het gesprek.
- Evalueer kort de opzet van het gesprek: wat werkte wel en wat minder?

Figure 33, Conversation Framework, instructions for the district nurse

INVULTEMPLATE T-DOOS: KENNISMAKINGSGESPREK

Datum kennismakingsgesprek:
Naam Wijkverpleger:

Naam cliënt:
Naam aanwezige naaste:

In te vullen door wijkverpleger:
Bespreek elke categorie aan de hand van de cirkel van vijf: Wat wil je bereiken -> hoe kunnen we daarvoor zorgen (Wat kan ik? Wat kunnen hulpmiddelen bieden? Wat kunnen mijn naasten? Wat kan er in de buurt/omgeving? Wat kan een professional of Surplus?). Laat cliënt en naaste meeschrijven op de afsprakenkaartjes.

PLEZIER
Ontdek wat de cliënt blij maakt en waar zij/hij energie van krijgt. **Maak samen een plan op om deze te fijne dingen te behouden of te versterken.**

Plannen: Welke dingen willen we behouden en versterken?	**Hoe kunnen we hiervoor zorgen?**	**Door wie?** Voeg contactgegevens toe waar mogelijk

DAGELIJKSE BEZIGHEDEN
Kijk welke dagelijkse activiteiten de cliënt nog zelf kan en wat lastiger is. Blijf positief en leg de nadruk op wat er nog wel kan, i.p.v. van er niet meer kan. **Maak samen een plan om de zelfstandige vaardigheden te versterken en om met moeilijkheden om te gaan of deze te verlichten.**

Voorbeeld verdiepende vraag:
- *Zijn er dingen in uw dag die u anders zou willen doen?*
- *Wat zijn de dingen die u belangrijk vindt om zelf te blijven doen? Wat wordt moeilijker?*

Plannen: Welke dingen willen we verlichten en welke zelfstandige vaardigheden kunnen we versterken?	**Hoe kunnen we hiervoor zorgen?**	**Door wie?** Voeg contactgegevens toe waar mogelijk

BLIK VOORUIT

Bespreek hoe de cliënt en naaste de toekomst zien. Wat hopen ze te doen of waar kijken ze naar uit? Waar zien ze tegenop of vinden ze spannend? Bied ruimte waarin ze hun angsten en zorgen verder kunnen toelichten. Het doel is niet om deze onmiddellijk op te lossen, maar om aan te moedigen dat deze onderwerpen bespreekbaar worden. **Maak samen een plan om toe te werken naar de mooie dingen in de toekomst en hoe om te gaan met de spannende en moeilijke dingen.**

Planen: Waar kunnen we naartoe werken en welke angsten kunnen we wegnemen?	**Hoe kunnen we hiervoor zorgen?**	**Door wie?** (voeg contactgegevens toe waar mogelijk)

Overige bespreekpunten:
(Denk aan levensverhaal, medicatie, alarmering, houding van cliënt naar nieuwe hulpmiddelen)

Figure 34, Conversation Framework, fill-in template consisting of three pages, to be filled in by the district nurse on either paper or via a laptop

07

Chapter 7

Evaluating the intervention

This chapter outlines the evaluation process of the intervention, discussing tests conducted with care recipients, informal carers, and district nurses to gauge their reactions and interactions with the intervention. The evaluation seeks to validate the desirability, viability, and feasibility of the intervention, as well as to gather recommendations for future improvements beyond the scope of this project.

7 | Evaluating the intervention

7.1 How do users respond to the intervention and what can be improved?

To validate my intervention ‘T-Doos’ and collect recommendations for further improvements I evaluated both the MVP (preparatory booklet + conversation framework) and the T-Doos (preparatory box + conversation framework) through various test sessions. The main goal of this evaluation is to investigate how the intervention performs regarding the design statement and if it properly addressed the intervention qualities as outlined in section 4.2.

Design Statement
"My goal is to support Surplus in fostering sustainable collective self-reliance through a value-based initial conversation between care recipient, their informal carer(s) and Surplus. This involves creating an adaptable overview of the care recipient's unique situation."

Intervention Qualities
- Dynamic
- Accessible
- Confidence
- Understanding & Trust

7.2 Method for evaluation

In total, I conducted 4 test sessions. From the test sessions two were held during a real intake with the MVP, and the other two with care recipients who are currently in home care tested the T-Doos. Each session had a slightly different set-up and goal and was tailored to the unique situation of the participant. This approach allowed for collecting a broad range of feedback and facilitated more targeted questions, building upon the previous test session. As for the different approaches, some focused on usability and others on the added value of the intervention, including its impact before and after use. I explored how the intervention could potentially contribute to collective self-reliance, address expectations beforehand, and foster a sense of responsibility. Additionally, I collected feedback on the MVP in discussions with three district nurses and during an innovation event. The evaluation setup is detailed in Table 4, highlighting the context of each participant and the specific aims of their test session and including the extra feedback collection moments as well.

Table 4, Evaluation method of intervention

Session	Goal of evaluation	Participants	Context	Instruments	Method
1	• Explore the conversation flow and exhaustiveness of the combination with the preparation booklet and conversation framework (Does it facilitate comprehensive understanding of the care recipient’s unique situation? Does it cover all topics necessary for an initial conversation for the district nurse?) • Explore the usability of the preparation booklet for care recipient and informal carer, identifying strengths, limitations and preferred mediums. • Explore applicability for users with a language barrier.	P1: Care recipient with language barrier, new to home care P2: Informal carer P3: District nurse	During real intake conversation	MVP: Preparation booklet + conversation framework	Email booklet; Videocall observation during conversation & reflective questions
2	• Explore the conversation flow and exhaustiveness of the combination of the preparation booklet and conversation framework. • Explore the usability of the preparation booklet for care recipient and informal carer, identifying strengths, limitations and preferred mediums.	P4: Care recipient, new to home care P5: 2 Informal carers P3: District nurse	During real intake conversation	MVP: Preparation booklet + conversation framework	Hand over booklet prior to conversation; Videocall observation during preparation and conversation & reflective questions
3	• Explore applicability for users with dementia. • Explore the effectiveness of the intervention: whether it clearly communicates what is expected of the users; encourages reflection on personal values; boosts confidence in managing their situation; and facilitates mutual understanding among all attendees.	P6: Care recipient with dementia, currently receiving home care P7: Informal carer, partner of care recipient P3: District nurse	Simulation of ‘Het Kennismakingsgesprek’ With a couple in home care, while making an video of the intervention in use	Final intervention: Preparation box + conversation framework	1st visit: Observation and filming during interaction with preparation box; Reflective questions 2nd visit: Observation and filming during conversation with district nurse; Reflective questions
4	• Explore the effectiveness of the intervention: whether it clearly communicates what is expected of the user; encourages reflection on personal values; boosts confidence in managing their situation; and facilitates mutual understanding among all attendees. • Explore the usability of the preparation booklet (focusing on exhaustiveness, comprehensibility, tone of voice).	P8: Care recipient in home care, difficulties in writing	Simulation of the preparation phase prior to an initial conversation, from the moment of receiving the preparatory box.	Final intervention: Prepararation box	Leave box at home; Pre- and post-use interviews (after 3 days)
5	Capture district nurses’ perspective on the applicability and added value of the intervention compared to the current intake process.	P9: Three district nurses	One-on-one conversation	MVP: Preparation booklet + conversation framework	Open discussion and reflective questioning
6	Explore adaptability and value across domains with a broad audience	P10: 40-50 visitors from Surplus and external stakeholders	Innovation kick-off event shift and share, 3 sessions of 20-minute presentation & interaction	Slidedeck; MVP: Preparation booklet + conversation framework	Short presentation of new approach to intake conversation; Making attendees fill in the preparatory booklet, Open discussion on adaptability across domains

7.3 Results of the evaluation

Since the preparatory booklet and the preparatory box contain nearly identical questions and layouts, their results are combined in the evaluation. Consequently, findings are organised by topic and perspective rather than by the type of instrument used. Figure 35 sketches the test setup and Figure 36 the innovation session.

Accessibility for the care reipients and informal carer

A language barrier made it impossible for the care recipient (P1) to fill out without the assistance of the informal carer. Resulting in the recommendation to make the intervention available in multiple languages in the future. In the second, with a native-speaking care recipient and two informal carers, questions were generally well-understood, though the informal carer experienced some difficulties in questioning. The district nurse effectively referred to the care recipient's responses in the booklet throughout the session.

Three out of four participants mentioned that the questions were easy to understand and it was clear what was expected from them. They appreciated the balance between open-ended questions and closed ended questions to tick off.

Some participants perfer to be adressed with the informal you instead of 'u', so I recommend to reconsider this in further development.

√ "The filling out wasn't difficult, and you should answer honestly to what's being asked." (care recipient, P4)

√ "I like having this on paper since I don't have a laptop myself, but preferences may vary from person to person. On paper, it's nice to have it open in front of you" (informal carer, P2)

! "The spaces provided for filling in are very small. For me, something digital would be better because I have difficulty writing." (care recipient, P8)

! I prefer to be addressed by my first name and to be referred to as 'you' instead of 'u' (the formal 'you')." (care recipient, P8)

Constraint for facilitating the conversation

The (district) nurses present acknowledged the value of preparatory work, facilitating in-depth discussions within a short timeframe on care recipient's needs and exploring possibilities for progress rather than focusing on negatives. The concerns raised, particularly regarding reporting practices and the possibility for duplication of work. Addressing these challenges may involve re-evaluating reporting methods to align with the new intake format in the future.

! "During the conversation, I was thinking a lot about filling it out, and I found it challenging to formulate goals immediately." (district nurse, P3)

The value of the value-based nature of the intervention, asking beyond the care questions

The project team was pleasantly surprised by the way of questioning from a different perspective, covering necessary intake topics without solely focusing on care-related questions. Also the care recipients said the T-Doos made them think of new things.

A concern among district nurses is that as you gather more information about what is important to the care recipient, expectations may rise regarding what Surplus should solve. Therefore, it's crucial not to attempt to solve all issues individually but to foster an environment where these concerns can be openly discussed. Despite the holistic approach of district nurses, their questions often still revolve around care recipient complaints. As such, a district nurse I spoke to regarding the section where care recipients are asked about what gives them joy:

√ "Oh, I actually never ask this. I usually focus on the negative and ask, 'what's not going well or where do you need help?' That's usually what I ask." (district nurse, P9)

√ "It has undoubtedly made me think about something I hadn't considered before. For example, the question of what is most important in the coming time? There could be hundreds of answers, but I said health, because I've experienced what happens when you're not completely healthy." (care recipient, P8)

Reponses to the tangibility of the intervention

The fact that the T-Doos is tangible eases the interaction with multiple people, enabling a shared conversation in a fun way.

√ The added value of a preparatory exercise and making it tangible through hard copy: "And when the children are there, they can do it together, and then you immediately encourage them to do something independently." (district nurse, P9)

Time freed up for deeper and efficient conversation

The preparation helps to bypass the barrage of questions and start the conversation on equal footing, with both parties adequately prepared.

√ "Preparation is helpful. There is no need for a barrage of questions anymore, so it's great that you can continue to inquire further right away." (district nurse, P3)

√ "I've already had 200 different people here myself. To ensure they know what they need to do here, it's useful to have this with you. There are care letters and care plans, but I think it's good for people in home care to be able to see at a glance what they need to do." (care recipient, P8)

√ Recognising the value of actively involving informal carers: "When an informal carer, for example, expresses their concerns and what they find important, It makes me think, where can I refer them to? What assistance can I provide them with? What can I do with those answers?" (district nurse, P9)

Relevance across domains

During an innovation kick-off involving 40-50 visitors from Surplus and external stakeholders, various responses were received. While some recognized this conversational approach, others were pleasantly surprised by what type of instrument could enhance such conversation. The potential relevance across multiple Surplus departments became clear, highlighting the need for consistency throughout the organisation. This is crucial as clients often move between departments, necessitating continuity in focussing on self-reliance and the personal plan created to support it.

! Not one size fits all

It's important to consider who is suited for this concept; sometimes the time between scheduling

an introductory meeting and the appointment date is too short to complete the preparation booklet. Therefore, the conversation framework can also be used solo. However, additional information may need to be made discussed, likely necessitating a follow-up meeting to fully create an overview the care recipient's situation.

Furthermore, there is variation among clients in the clarity and urgency of their care requests when scheduling an appointment: "For example, in the case of target group 5 meetings, the focus is not immediately on a care request, and the question is less concrete. In contrast, there are also cases when someone who only needs support stockings has a specific and concrete request." (District nurse) Here it is important for the district nurse to adapt their conversational approach accordingly, so that in this care for example, they focus more on the future goals and challenges, aiming to keep individuals out of the care system by proactively exploring possibilities to increase collective self-reliance.

FIgure 35, Test set up with couple in home care

FIgure 36, Sharing the intervention during innovation kick-off at Surplus

08

Chapter 8

Implementing the intervention

This chapter explores how Surplus can implement the intervention. It outlines short-term implementation strategies, examining how the intervention aligns with existing workflows and what it could potentially replace. Furthermore, it discusses the long-term implications of a shift towards coaching roles. It anticipates the roles it may play in moving towards the desired directionality ('A caring society that focuses on what is still possible rather than limitations, aiming for a meaningful life. Where self-reliance is a collective effort, and each individual is truly recognized).

8 | Implementing the intervention

8.1 How can Surplus implement the T-Doos in the short term?

Readiness of intervention materials

For short-term implementation, the MVP preparation booklet and conversation framework are ready for use. However, the conversation framework requires integration with the current Omaha reporting system to avoid double reporting by district nurses. Fortunately, the intervention's topics cover the necessary information for the Omaha system, found in the completed booklet or discussed during the conversation, potentially simplifying reporting integration.

The implementation of the T-Doos requires additional time and investment for assembly after printing and for creating tea bags with value-based questions. All materials, such as preparation instructions, question cards, appointment cards, and the laser-cut box, are ready for printing.

Integration into current workflow

Figure 37 illustrates how the intervention can be integrated into the home care intake process, highlighting changes in the current process. Additionally, to understand what actors are directly involved in short-term implementation, I created an example scenario in the system map, shown Figure 38.

The need for clear guidelines and quality standards

Formulating guidelines for the use of 'Het Kennismakingsgesprek' is essential, considering the diversity in care recipient situations, such as cognitive or physical abilities and the presence of informal carers. If a care recipient is unable to complete the booklet due to cognitive or physical conditions and lacks informal caregiver support, the conversation framework can still be employed for discussion. However, to get to the same level of detail, the preparation package can be provided afterwards and support in the next conversation. I suggest further research into an more fitting name for the preparation package. Additionally, the variations in time between making and attending the introductory, necessitate clear guidelines preparation's appropriateness. In conclusion, guidelines and quality standards need to be established to ensure that the preparation process is effective and fits to one's unique situation, ensuring care recipients feel understood and gain confidence, enabling possibilities can be explored collaboratively.

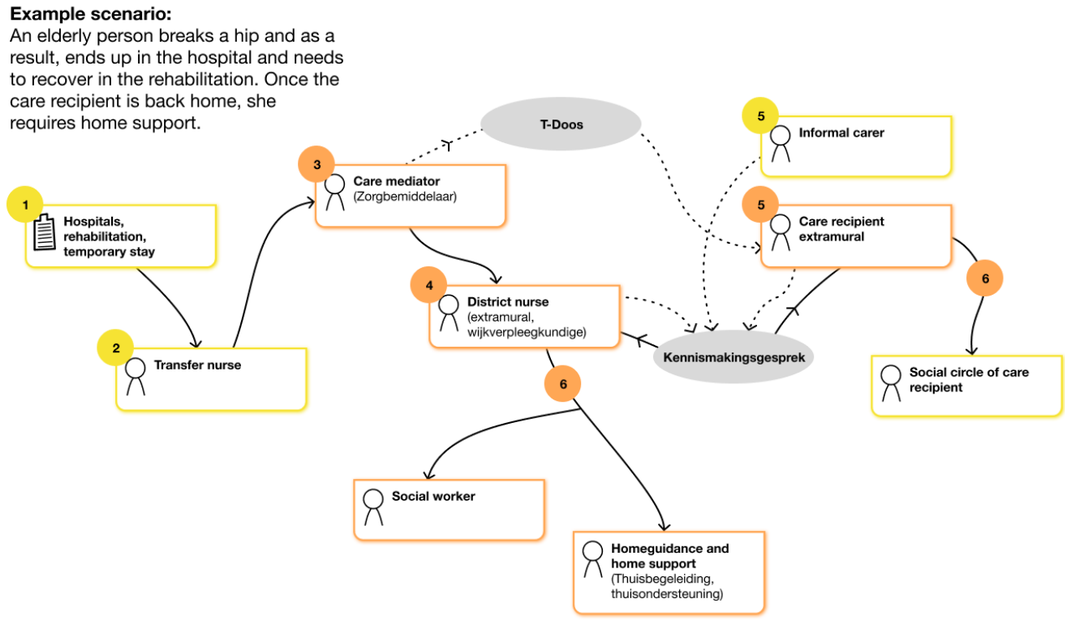


Figure 38, Example scenario when implementint T-Doos and its actors involved within the elderly care system

Figure 37, Intake process when intervention is implemented

8.2 How can Surplus work towards the desired directionality? Implications for the long-term

In this section I explore the importance of coaching roles in achieving the desired directionality. While initiating this change is possible in the short term, it requires broader organisational commitment and training, potentially even beyond Surplus.

8.2.1 Shift from caring role to coaching role

To foster collective self-reliance, I see the need for ongoing involvement beyond the initial conversation, necessitating a shift from caring to coaching roles within or even beyond the elderly care system. Inspired by my analogy, this transition positions a coach as a key supporter of the care recipient and informal carer during and after the usage of the preparation package (coachboard). The T-Doos and the introductory conversation is just a start, laying the foundation for understanding the care recipient's unique situation and initiating a conversation on potential support strategies. This value-based and personal approach emphasises opportunities over constraints and must continue, adapting to the changing needs and environment of the care recipient and informal carer (dynamic). As care recipients and informal carers are encouraged to take proactive steps post-introductory meeting, a Surplus staff member or another designated individual may adopt a coaching role, guiding them in their journey to becoming as collectively self-reliant as possible.

Below I outlined various perspectives on adapting coaching roles in elderly care. Following this, in section 8.2.2 I translated these perspectives into what this coaching role should contain.

The perspective of a trainee caregiver

A Surplus intern and caregiver in training highlights the crucial role of professional care contact for a care recipient (personal communication, March 6, 2024). This contact provides an understanding from a care perspective, including physical discomforts and necessary measures that can make someone feel better, which cannot be fully replaced by informal care.

The shift to a coaching role requires clear communication in the initial conversation with care recipients and informal carers. It's essential to assure and communicate that necessary care will continue, but in a new way, emphasising support without directly solving problems: "Je kan op ons bouwen!" ("you can rely on us") (Caregiver in training, personal communication, March 6, 2024).

Despite the holistic, value-oriented approaches taught in education, in practice, differences in willingness to adopt new approaches exist within the organisation among caregivers. It is recommended to focus on those with a holistic view and willing to embrace new approaches, such as the coaching role transition.

The perspective of a lecturer in higher vocational nursing education

To better understand the role of education in transitioning to a coaching role of caregivers, I consulted W. Moorlang, a lecturer in higher vocational nursing education (personal communication, March 13, 2024). Our conversation revealed that HBO nursing education is actively integrating living labs and innovations to prepare students for the evolving landscape of elderly care. Focusing on holistic approaches and positive health, students learn the importance of understanding care recipients' goals and shared decision-making. Originally, the approach has always been for nurses to do only what is necessary, especially now with increasing pressure, they no longer spend time on simple care requests, allowing people to manage these themselves. The curriculum responds to government policies promoting community-based care and calls to informal carer, teaching students to signal informal carer overload and provide the necessary support. Despite the educational sector's readiness for change, the shift towards a more coaching-oriented role is challenged by systemic issues such as task-focused healthcare organisations and a production-oriented financing system. As such, in organisations, team dynamics, and the way innovations and interns are managed play a crucial role in facilitating this shift.

The perspective of people in managing positions at Surplus

The Program Manager of Social Innovation recognised 'T-Doos' as a step towards nurses adopting a more holistic and critical view in understanding care recipients' unique situations, a key aspect of transitioning to a coaching role (T. van der Vange, personal communication, March 19, 2024). Following the manager of district nursing and the project team Intake 2.0, Surplus has sufficient knowledge to foster sustainable relationships with care recipients and informal carers and to shape a coaching role (personal communication, March 6, 2024). As such, lessons can be drawn from the Social Approach to Dementia (SBD). For instance, when a social worker in a community center identifies early signs of dementia, an SBD team member, acting as a non-medical coach, is assigned to support the individual, focusing on enhancing their life. This ensures the care recipient and informal carer have a consistent point of contact for support through various stages, offering domain-transcending guidance.

The importance to keep on engaging one's network and the potential of digital care are highlighted, with video calls allowing for brief check-ins. Additionally, the Circle of 5 is seen as an essential mindset for coaching roles.

The concern in transitioning to a more coaching role is whether there is sufficient room to fulfil such a role and its associated tasks. These tasks need to be incorporated into the care pathway, which depends on budgeting. A care pathway outlines the steps a care recipient goes through and the actions taken by caregivers at each stage (Palliaweb, n.d.). "For example, a care pathway might allocate 40 hours for home care, requiring budget-focused attention in adopting a coaching role" (T. van der Vange, personal communication, March 19, 2024).

The perspective of an expert in appropriate care (value-based approach)

To bridge the gap between a coaching role and a value-driven approach, and to gain a broader perspective on how to address the overall changes in (elderly) care, I consulted Jan Kremer, Professor of Healthcare and Society and Special Envoy for Appropriate Care (personal communication. March 18, 2024).

Kremer acknowledges the significant role of district nurses because they are closer to people's lives than doctors, who are closer to their illnesses. He sees opportunities for broadening the coaching role beyond healthcare professionals, highlighting community-driven initiatives where unpaid individuals significantly contribute to the meaningful life of care recipients.

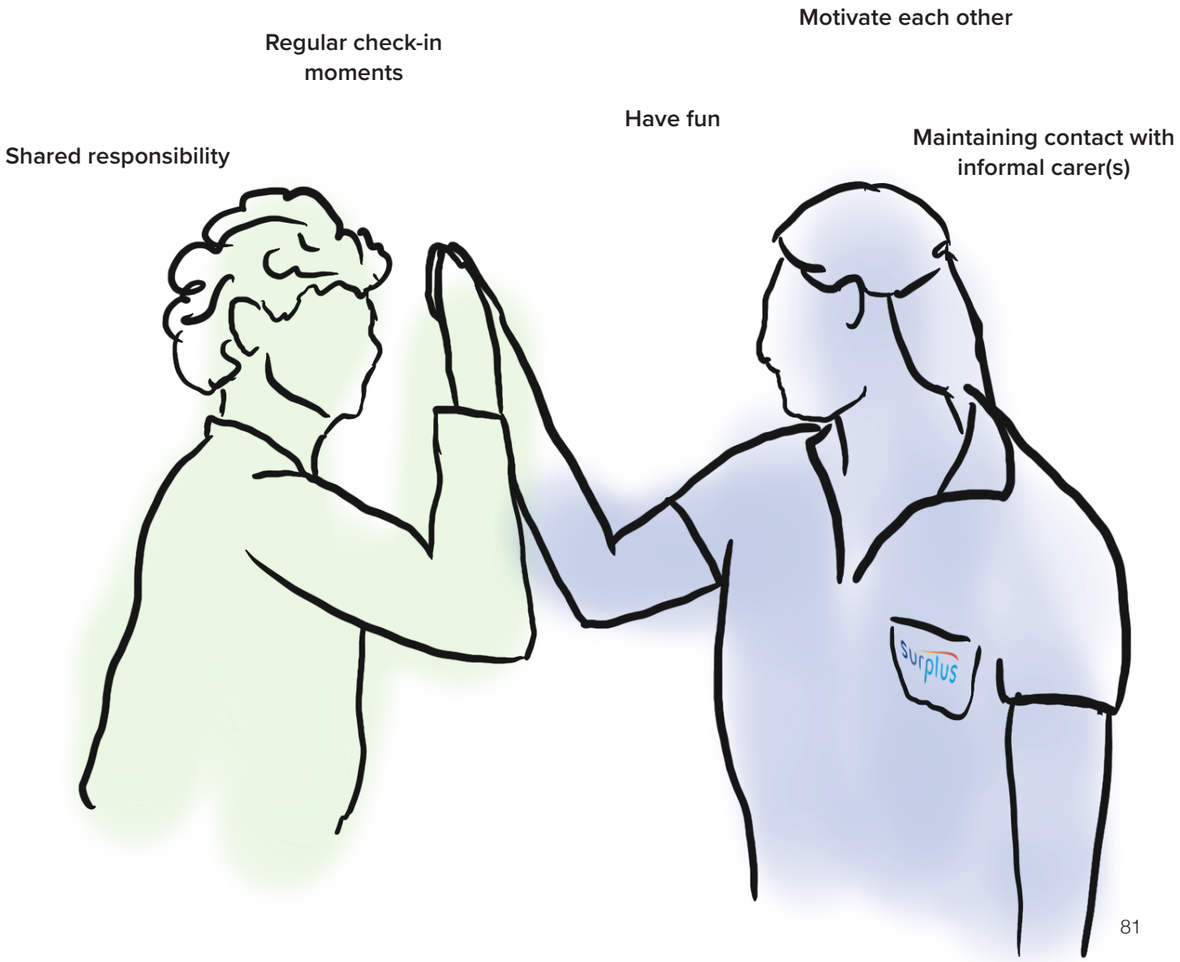
Kremer advocates for making the care transitions fun and hopeful and avoid making it a cynical movement. Given the complexity of challenges in elderly care, a learning movement and exploring boundaries of domains is crucial: *"A learning movement means a lot of togetherness which means that you don't find other perspectives irritating but interesting and that they are useful for taking next steps. And with that comes an attitude of curiosity of connection and also some humility." (J. Kremer, personal communication. March 18, 2024).*

8.2.2 Conclusion on an anticipated coaching role

Having captured various perspectives on the coaching role in elderly care to promote collective self-reliance and ensure care recipients lead meaningful lives with the people surrounding them, I suggest the following for how this coaching role could look.

With a coaching role at Surplus, you are expected to check in regularly with the care recipient and their informal carer, either in person or via video call, concentrating on pleasure, daily activities, and future outlooks of the care recipient. You motivate, support and have fun, just like a coach on the hockey pitch, uniting the team towards collective self-reliance through individual strengths and perseverance, without bringing in all solutions yourself. As a coach along the pitch, you give confidence and offer guidance when needed.

Integrating a dynamic personalised plan into the systems across different domains in elderly care is crucial for a comprehensive understanding of the care recipient's situation (e.g. including things important to their lives and information on their network). Given the constraints within the system, having one consistent contact person may not always be feasible. Further research should explore practical ways to implement these plans, address budgeting concerns, and explore merging care and well-being services. This includes determining who is most suitable for the coaching role, also beyond nursing roles.



09

Chapter 9

Conclusion, Discussion and Personal reflection

9 | Conclusion, Discussion and Personal reflection

9.1 Conclusion

Within the numerous challenges at play in elderly care, this project has concentrated on the core human values central to both receiving and providing care, aiming to reshape the caregiving role towards shared responsibility. This aligns with the project's initial goal and fuels the second objective: Design an intervention that consciously incorporates these values, assisting Surplus in guiding the shift to a new care standard.

The exploration into values and the tensions arising from the increasing pressures on elderly care highlighted a collective desire to maintain meaningful contact, identified the strengths and pitfalls of benevolence and the necessity of aligning expectations. It became evident that there is a significant overlap in values between those receiving and providing care, blurring the traditional lines between caregiver and care recipient roles and creating opportunities for intervention. The initial conversation in home care emerged as a moment to intervene, set expectations, and address possibilities while paying attention to the values that are important to the ones involved. This moment serves as a stepping stone towards fostering collective self-reliance, focusing on possibilities rather than limitations and aiming for a meaningful life, as reflected by the adopted desired directionality in this project.

The T-Doos introduces a new approach to the current intake conversation in home care, comprising a personal preparation package that includes the T-Doos, delivered to the care recipients' home, and a framework for the introductory conversation. It invites them to think together with their loved ones about what is important to them in daily life, who they are in contact with, what makes them happy and how they look ahead. It forms the basis of the conversation with the district nurse in which possibilities are explored together and agreements are made. By encouraging care recipient and informal carer to think beyond the immediate care question and offering a contrast to existing intake procedures, the T-Doos is designed in the language of its users focusing on tangible topics. This aims to enable them to take control of their situation, and have an equal conversation with the district nurse, promoting mutual support and collective self-reliance.

With the T-Doos, in the first moment of contact with Surplus, there is an opportunity to change their character at the frontline and help in aligning expectations and establishing shared responsibility. However, to achieve sustainable collective self-reliance, further research is necessary to pinpoint exactly what is required in the dynamic between Surplus and its clients, including the aspect of the coaching role.

9.2 Discussion

Opportunities for my fellow design practitioners

For fellow design practitioners, there is a significant opportunity to address challenges in elderly care. Particularly as our society increasingly emphasizes efficiency and individualism, alongside a growing call for shared responsibility and a more caring society. This tension creates a unique opportunity for designers to capture diverse perspectives, especially concerning the blurred lines between receiving and providing care roles. While values may already overlap, a sense of responsibility may not yet be fully realized. This calls for actionable solutions that embrace this overlap.

The potential use of the T-Doos across the elderly care system

The intervention, initially designed for district nursing with the assumption of their holistic perspective and conversational skills, faces challenges with expanding pressures in care. Given the likelihood of caregivers from diverse educational backgrounds conducting intakes, there is a need for this intervention to adapt for those less familiar with such value-based conversations. This adaptation might require additional research to identify effective usage methods, possibly including training for nurses on creating personalised plans using the intervention's framework.

Additionally, I see the potential to extend the intervention across different domains. An occupational therapist during an innovation session noted the use of similar questions but without a structured tool like the preparatory exercise, suggesting room for broader application (personal communication, February 1, 2024). Within Surplus, there are similarities, but the organisational silos hinder direct connection (Expert SBD at Surplus, personal communication, March 14, 2024). The Social Approach to Dementia (SBD) philosophy, by Anne-Mei The, highlights the care recipient's world and potential for happiness rather than protocols, in which the medical aspect does play a role, but is never paramount (ZonMw, 2022). This philosophy overlaps with the topics covered during 'Het Kennismakingsgesprek' and thus offers an opportunity to connect the approaches. Future research should explore integrating the intervention throughout the elderly care system. So that for example, it results into a uniform care plan from GP, via rehabilitation to home care. Achieving such uniformity could help care recipients and their informal carers maintain overview and control from the start of needing support until the end of life. This could reduce the need for repeating their personal story over and over, and for the professional caregivers it could allow for quicker, more appropriate care delivery. Additionally, research should examine how funding streams can align with the intervention, or vice versa, to ensure seamless integration and support.

Comparison with other tools

T-Doos focuses on concrete and personal aspects of the care recipients' daily lives or social interactions making it easier for them to engage. Unlike other tools that mainly ask for information without establishing concrete agreements, my instrument encourages the creation of personal agreements, enhancing the care recipient's autonomy. Additionally, it allows for continuous updating, supporting ongoing self-reliance. Like my instrument, there are tools facilitating meaningful conversations and navigating tough topics, improving communication and aligning expectations as mine does, but my instrument's actionable approach and the simplicity in its tangible questions sets it apart.

Limitations and future study

For this study I conducted 11 interviews, which was sufficient for my study goals but could be expanded for greater significance in future research. Furthermore, the interviews involved care recipients currently in intramural care, whereas my intervention targets new care recipients in homecare. Although the participants were seen as experts in receiving care, this may have introduced biases, such as in their expectations of care. Therefore, the intervention needs further testing with extramural care recipients to better align with their desires, especially if there appears to be a big difference in needs between those receiving care intramural or extramural.

Additionally, I tried out various methods during the interviews to uncover values, such as using Playmobil, relationship maps, or different questioning techniques. While this exploratory approach enriched the insights, a more structured method could provide more definitive conclusions.

In terms of the interview setup, the focus was primarily on exploring the presence of values rather than determining their relative importance to each other. While this approach served as inspiration for understanding what is important to those involved in receiving or providing care, it may be beneficial for future studies to delve deeper into prioritising these values. This would aid in not only identifying significant values but also in exploring ways to encourage reflection on these values among participants.

9.3 Personal Reflection

The multitude of opportunities to innovate and support ongoing changes in elderly care makes me enthusiastic to continue. However, the approaching project deadline brings a sense of closure, and I am very happy with the contributions made for Surplus, exceeding my initial expectations.

In between the elderly

Working within a nursing home environment from the project's inception broadened my perspective. Engaging directly with stakeholders was fun and involved many surprising talks and perspectives. It also revealed that my role as a designer is about bridging different perspectives rather than about understanding every detail, as the stakeholders themselves are already the experts in care.

A desire for leaving a lasting impact

My personal goal for this project was to graduate with the feeling that the client could carry it forward independently. Yet, this ambition led me to become somewhat overly focused on leaving behind something tangible, driven by the multitude of societal issues and the urge to contribute wherever possible. While this approach allowed me to make a significant impact within a limited timeframe, it also challenged my preferences as a designer. I usually like to focus on the big picture and thrive on creative brainstorms, speculative design, and finding unique and crazy solutions. My supervisor quickly noticed this inner conflict, which helped me realise what I enjoy doing most and where my strengths lie, which Iwill carry beyond this project.

Wanting to make yourself proud.

Where independence in the project offered freedom to tailor my own approach, it also came with a sense of responsibility, especially towards oneself. In group work, which I am used to, mutual motivation and shared responsibility for a particular outcome are common. However, when working alone, you are the one to make yourself proud, which has often led me to set the bar very high and pursue ambitious plans that may not always be entirely realistic. For example, between green-light and graduation I was excited to create a video, developing a prototype, and conduct expert interviews, which left little time to get my structure my narrative. I am aware of this tendency and hope to gradually improve it. Nevertheless, this independence has also presented some exciting opportunities, such as the chance to organise a workshop for 45 participants, as seen in Figure 39. Though it required extra effort, it gives energy and as sense of accomplishment.

Values-based and systemic approaches

Initially, I believed there were fixed methods for designing with values or systemic design. However, I discovered that these concepts were less strict and already defined. Exploring these ideas alongside the fun and supportive spar sessions with supportive supervisors challenged me to experiment with various design methods, empowering me to trust my intuition and adapt my approach based on context.

FIgure 39, Facilitating workschop at De Leercommunity, for 45 people active in care ans healthcare technology, October 2023

Chapter 10

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10

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Chapter 11

Appendices

11

11 | Appendices

0. Initial project brief
1. Interview guides per participant group
2. Codebook for data analysis of uncovering values
3. Values and its definitions as adopted for this research
4. Nine emerged themes explained
5. Overview of design process towards the MVP
6. Three concept ideas pitched to the project team ‘Intake 2.0’
7. Desired input and output of the two chosen concepts
8. Design iterations from MVP to T-Doos
9. MVP: preparation booklet & conversation framework
10. T-Doos: Question cards and teabags

0. Initial project brief

TU Delft

DESIGN FOR our future

IDE Master Graduation Project

Project team, procedural checks and Personal Project Brief

In this document the agreements made between student and supervisory team about the student’s IDE Master Graduation Project are set out. This document may also include involvement of an external client, however does not cover any legal matters student and client (might) agree upon. Next to that, this document facilitates the required procedural checks:
- Student defines the team, what the student is going to do/deliver and how that will come about
- Chair of the supervisory team signs, to formally approve the project’s setup / Project brief
- SSC E&SA (Shared Service Centre, Education & Student Affairs) report on the student’s registration and study progress
- IDE’s Board of Examiners confirms the proposed supervisory team on their eligibility, and whether the student is allowed to start the Graduation Project

STUDENT DATA & MASTER PROGRAMME
Complete all fields and indicate which master(s) you are in

Family name [redacted]
Initials
Given name
Student number

IDE master(s) IPD ☐ Dfl ☐ SPD ✓
2nd non-IDE master
Individual programme (date of approval)
Medisign ☐
HPM ☐

SUPERVISORY TEAM
Fill in he required information of supervisory team members. If applicable, company mentor is added as 2nd mentor

Chair	Mieke van der Bijl-Brouwer	dept./section	DOS/MOD
mentor	[redacted]	dept./section	DOS/MOD
2nd mentor			
client:			
city:		country:	The Netherlands
optional comments	systemic design, Marina’s expertise … get a deeper understanding in the relationships that shape the system, identifying values and conflicts are key.		

! Ensure a heterogeneous team. In case you wish to include team members from the same section, explain why.
! Chair should request the IDE Board of Examiners for approval when a non-IDE mentor is proposed. Include CV and motivation letter.
! 2nd mentor only applies when a client is involved.

APPROVAL OF CHAIR on PROJECT PROPOSAL / PROJECT BRIEF -> to be filled in **by the Chair** of the supervisory team

Sign for approval (Chair)
Mieke van der Bijl-Brouwer — Digitally signed by Mieke van der Bijl-Brouwer Date: 2023.10.12 09:46:17 +02'00'

Name Mieke van der Bijl-Brouwer Date 12 Oct 2023 Signature

L OF CHAIR on PROJECT PROPOSAL / PROJECT BRIEF -> to be filled in **by the Chair** of the supervisory team

approval (Chair)
Mieke van der Bijl-Brouwer — Digitally signed by Mieke van der Bijl-Brouwer Date: 2023.10.12 09:46:17 +02'00'

Mieke van der Bijl-Brouwer Date 12 Oct 2023 Signature

CHECK ON STUDY PROGRESS
To be filled in **by SSC E&SA** (Shared Service Centre, Education & Student Affairs), after approval of the project brief by the chair.
The study progress will be checked for a 2nd time just before the green light meeting.

Master electives no. of EC accumulated in total ____ EC
Of which, taking conditional requirements into account, can be part of the exam programme ____ EC

★	YES	all 1st year master courses passed
	NO	missing 1st year courses

Comments:

Sign for approval (SSC E&SA)
Robin den Braber — Digitaal ondertekend door Robin den Braber Datum: 2023.11.14 08:35:21 +01'00'

Name Robin den Braber Date 14 nov 2023 Signature

APPROVAL OF BOARD OF EXAMINERS IDE on SUPERVISORY TEAM -> to be checked and filled in by IDE’s Board of Examiners

Does the composition of the Supervisory Team comply with regulations?

YES	★	Supervisory Team approved
NO		Supervisory Team not approved

Comments:

Based on study progress, students is …

Comments:

Sign for approval (BoEx)
Monique von Morgen — Digitally signed by Monique von Morgen Date: 2023.11.14 09:16:53 +01'00'

Name Monique von Morgen Date 14 Nov 2023 Signature

Personal Project Brief – IDE Master Graduation Project

Name student Ianthe van Alkemade **Student number** 4,662,911

PROJECT TITLE, INTRODUCTION, PROBLEM DEFINITION and ASSIGNMENT
Complete all fields, keep information clear, specific and concise

Project title Reshaping responsibility and autonomy in elderly care for a resilient care system and society

Please state the title of your graduation project (above). Keep the title compact and simple. Do not use abbreviations. The remainder of this document allows you to define and clarify your graduation project.

Introduction

Describe the context of your project here; What is the domain in which your project takes place? Who are the main stakeholders and what interests are at stake? Describe the opportunities (and limitations) in this domain to better serve the stakeholder interests. (max 250 words)

The rising pressure on healthcare, driven by a growing elderly population, caregiver shortages, and strained public finances, challenges the obviousness that care will always be readibly available. This necessitates a shift towards greater autonomy and shared responsibility in elderly care.

In the global quest for sustainable healthcare and resilient society, the convergence of healthcare professionals, digitalisation, and communities is increasing. Besides the importance of retaining and attracting care workers (475.000 care workers, a third of whom will retire in the next 10 years) **(Westerlaken, 2023),** there is a growing recognition of the need to integrate informal care alongside professional care. This transition isn't about more care, but rather less, which, according to Integraal Zorgakkoord (IZA) means that as a society we must adapt to managing with less and fewer hands at the bedside (Rijksoverheid, 2022). Additionally, the Ministry of Health, Welfare and Sport has introduced the national WOZO program for setting a new standard: "by yourself if you can; at home if you can and digitally if you can (2022). This emphasises a more caring society, wherein one's self and relatives become part of the healthcare system (Kremer, 2023).

In this context, Surplus, an organisation providing comprehensive elderly care services in West Brabant, faces questions about its role in adapting to evolving responsibility and autonomy in elderly care. WOZO is a given, but its interpretation remains open, offering an opportunity for designers to shape its direction.

In my graduation project, I will explore how Surplus can navigate a systemic shift towards a desired direction that includes an increase of autonomy, by applying systemic design. This involves identifying the values of stakeholders within my target group* and addressing potential value conflicts that may arise during this shift.

**Target group: elderly individuals with physical complaints (prospective clients), their social circles (family and relatives), and caregivers.*

→ space available for images / figures on next page

image / figure 1 *A quick overview of the current situation in elderly care (left), plans to tackle the care challenge(right)*

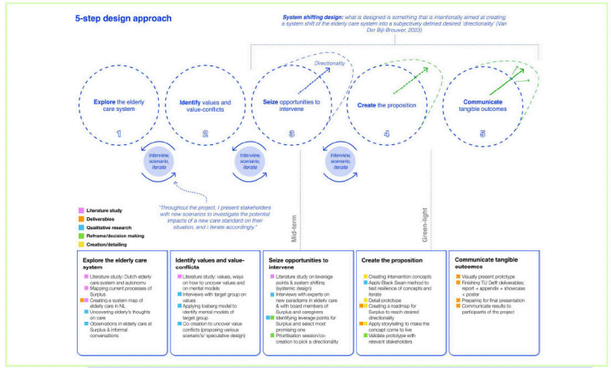


image / figure 2 *5-step design approach of my graduation project*

Personal Project Brief – IDE Master Graduation Project

Problem Definition

What problem do you want to solve in the context described in the introduction, and within the available time frame of 100 working days? (= Master Graduation Project of 30 EC). What opportunities do you see to create added value for the described stakeholders? Substantiate your choice.
(max 200 words)

Surplus' care-professionals currently face challenges in conveying the importance of clients maintaining their self-reliance for as long as possible. Despite their efforts, conversations often result in disappointment or surprise from clients and their relatives, who feel they have a right to receive care. Caregivers bear the brunt of these reactions, even though it's a broader social shift. This raises the initial question: "How can we better align expectations between caregivers and the elderly who need care, while preserving caregivers' job satisfaction?"

Subquestions:

- What does my target group value and more specifically in care? What do they believe they are entitled to?
- To what extent are they willing to be independent or take care of each other?
- Are there any conflicting values that arise in a certain situation?
- What type of conflicts arise? (people's inner conflicts, in relationships, between target group/care system)
- How are the uncovered values influenced by one's paradigm?
- Organisationally speaking, what directionality should we pursue during the transition?
- What leverage points can we identify and on which can Surplus exert the most influence?
- What interventions can Surplus implement to assist older individuals in achieving greater autonomy in healthcare while simultaneously maintaining job satisfaction among caregivers?

Assignment

This is the most important part of the project brief because it will give a clear direction of what you are heading for. Formulate an assignment to yourself regarding what you expect to deliver as result at the end of your project. (1 sentence) As you graduate as an industrial design engineer, your assignment will start with a verb (Design/Investigate/Validate/Create), and you may use the green text format:

My design goal is to 1) identify and address values related to elderly care and minimise potential conflicts during the shift to greater autonomy for elderly and their social network. 2) Design an intervention that consciously incorporates these values, assisting Surplus in guiding the shift to a new care standard.

Then explain your project approach to carrying out your graduation project and what research and design methods you plan to use to generate your design solution (max 150 words)

In this project, I'll use a systemic design approach to shift the elderly care system in the Netherlands, focusing on values and value conflicts through research-by-design and co-creation. I'll follow a 5-step approach (figure 2):
1. Explore elderly care system
Understand the Dutch elderly care system through literature, interviews and system mapping.
2. Identify values and value-conflicts
Uncover values and value tensions related to elderly care through interviews and co-creation.
3. Seize opportunities to intervene
Collaboratively envision the desired directionality (system shifting, figure 2) for the elderly care system from the Surplus' organisational perspective and identify leverage points. Select the the most influential leverage point for Surplus and create intervention concepts.
4. Create the proposition
Detail interventions from phase 3, making design decisions that ensure Surplus can effectively implement them.
5. Communicate tangible outcomes
Develop materials, deliver presentations, and provide feedback to project participants.

anning and key moments

*sible how you plan to spend your time, you must make a planning for the full project. You are advised to use a Gantt at to show the different phases of your project, deliverables you have in mind, meetings and in-between deadlines. Keep in mind that all activities should fit within the given run time of 100 working days. Your planning should include a **kick-off meeting**, **mid-term evaluation meeting**, **green light meeting** and **graduation ceremony**. Please indicate periods of part-time activities and/or periods of not spending time on your graduation project, if any (for instance because of holidays or parallel course activities).*

Make sure to attach the full plan to this project brief.
The four key moment dates must be filled in below

Kick off meeting	25 Sep 2023
Mid-term evaluation	14 Nov 2023
Green light meeting	31 Jan 2024
Graduation ceremony	29 Feb 2024

In exceptional cases (part of) the Graduation Project may need to be scheduled part-time. Indicate here if such applies to your project

Part of project scheduled part-time	
For how many project weeks	
Number of project days per week	

Comments:

Motivation and personal ambitions

Explain why you wish to start this project, what competencies you want to prove or develop (e.g. competencies acquired in your MSc programme, electives, extra-curricular activities or other).

Optionally, describe whether you have some personal learning ambitions which you explicitly want to address in this project, on top of the learning objectives of the Graduation Project itself. You might think of e.g. acquiring in depth knowledge on a specific subject, broadening your competencies or experimenting with a specific tool or methodology. Personal learning ambitions are limited to a maximum number of five.
(200 words max)

I am excited diving into a relatively new topic for me. The complexity and the pressing need for change in the healthcare sector, as well as how society perceives it, have captured my interest. Conversations with my grandparents, highlighted the challenges of aging and care shortages due to varying expectations: "I don't want to think about my final years just yet; I'll cross that bridge when it comes." "I'm currently paying a monthly fee to a care provider in my neighbourhood, so I expect that help will be available when I need it." "We might consider a community home to live together, but there's a long waiting list." "I don't anticipate that our family can help, but I notice the importance of being attentive to each other, like checking in during my daily swim session."

Learning goals:

- Effectively communicating what systemic design is and how it can be used to address complex challenge as those in elderly care.
- Apply systemic design methods and uncover values and value conflicts in healthcare
- Manage projects by setting realistic goals and maintaining honesty within my team.
- Gain firsthand knowledge of the Dutch healthcare system (+ on-site observation).
- Discovering opinions and motivations that shape future seniors' perceptions of aging and the current healthcare system.

1. Interview guides per participant group

In part one I started with introducing myself to make the participant familiar with the person facing them and to invite them to share something personal as well. Following this, I posed general questions to get to know the participant, and gain insight into their background and current engagement in receiving or providing care. The intention behind these questions was to keep them easy to answer, allowing a comfortable atmosphere and to help the participant ease into the interview.

Part two aimed to reveal participant's current care-related values through zooming in on a specific care moment, namely the moment of going to bed. Because every care recipient needs different kind of support, I sought a universal moment where most care recipients receive some kind of assistance from a caregiver. In consultation with Surplus, we arrived at the bedtime moment. The decision to focus on a specific situation or context is grounded in Coeckelberg's view on how a 'Value is neither to be described nor to be created; it has to be lived' (2012). Due to the abstract nature of values, emphasis lays on descriptive questions follow-up 'why?' questions to reveal underlying feelings and motivations during this moment and in their interaction with the care recipient or caregiver. This is later translated into values. I used Playmobil as a creative tool to make the situation tangible, stimulating the participant to describe their experience step by step. In the meantime, I ask deepening questions about the important things for each step. For example: 'How important is it for this person to help you with this? And why?'.

In part three I introduced a future scenario projected onto the same situation as in part two. I posed questions about how this situation would look like in this future scenario and to whom they would ask for help if necessary. The goal is to identify if and how current values change in this future context. Questions here are raised to stimulate thinking about shifts in meaning in separate values (Boenink & Kudina, 2020).

In Part four I zoomed out and asked participants about their definition of care. The aim is to discover their perception on care and how their relationships influence this perception, and what care would look like according to their meaning of care. Additionally, I asked a personal question to highlight the key elements of receiving care and providing care, to later translate into values. For example: 'Imagine one of your loved ones ends up in a long-term care situation, for example, after a hip fracture. What kind of care do you hope they receive, and what is most important to you?

Future care recipients

Introductie

Dank voor uw tijd en bereidheid om deel te nemen aan dit interview. Ik ben Ianthe en [..korte intro]. Ik ben geïnteresseerd naar de waarden die voor u belangrijk zijn in zorgen voor u zelf en zorg ontvangen van anderen, welke verwachtingen er heersen en hoe deze tot stand komen. Ik ben dat, waar woont u?

Dit interview is onderdeel van mijn afstudeerproject en de bevindingen worden gebruikt voor mijn afstudeerverslag.
- Ik zit hier vanuit een neutral rol en ben vooral benieuwd naar uw blik en ervaringen.
- Vindt u het oké als ik dit gesprek opneem, zodat ik de inzichten achteraf goed kan verwerken?
- Achteraf zullen we kort door een toestemmingsformulier doornemen die u vervolgens kan tekenen.
- Als u vragen heeft kunt u die gedurende het hele interview stellen en als u zich op welk moment dan ook wilt terug trekken, dan is dat uiteraard mogelijk.

Dit interview bestaat uit 3 onderdelen
- Algemene vragen -> om begrip te krijgen in uw huidige situatie en weg naar waar u nu bent.
- Inzoomen op een moment van uw dag, het naar bed ga moment. Welke handelingen vinden er plaats en wat vindt u belangrijk tijdens dit moment?
- Uitzoomen en hebben over wat zorg voor u betekend en hoe deze betekenis tot stand komt.

1. Algemeen

Objective: To emphasise with my participants and to enable me to make the questions that will follow more personal.

Q1: Kunt u mij iets over u zelf vertellen? Waarom u hier woont en hoe lang al bijvoorbeeld
- Waar heeft u hiervoor gewoond, wat voor beroep gedaan?
  - Wat was uw keus om hier te komen wonen? En hoe bent u hier bij gekomen?
- Waar houdt u zich zoal mee bezig?
- Leeftijd
- Ontvangt u momenteel een vorm van zorg?

2. Sociale cirkel

Objective: Identifying relations of the participant, to gain a feeling of their social network, who might play a role in caregiving in a later stage. Uncovering link between relations and values.

Met behulp van Playmobile gaan we de volgende vragen behandelen. Playmobile dient voor het voor het tastbaar maken van de relaties en onderwerpen die we bespreken. Zo kunnen we makkelijk verwijzen naar verschillende mensen die een rol spelen in dit onderwerp.

Q2: Kunt u voor mij met de playmobile uitleggen met wie u regelmatig in contact bent? Dit betreft uw sociale cirkel, maar denk ook aan instanties of organisaties waar u mee te maken heeft.

Q3: Kunt u de relaties en verhoudingen met deze personen omschrijven? (Intensity/power related)
- Wat vindt u belangrijk in de verschillende relaties?

3. Een blik vooruit

Objective: Identifying and challenge future values in projection to the relation map (how do relationships change, which one becomes strengthened and which one weakenens)

Scenario schetsen: Stel we spoelen iets door vooruit en u wordt wat vergeetachtig en breekt een heup, je bent niet meer in staat zelfstanding de hele dag door te komen, u bent afhankelijk geworden van langdurige zorg. & Zoom in context van bed situatie.

Q4: Bent u wel eens met dit moment bezig? Op welke manier (hoe bereidt u zich voor?)?
- Op welke manier verwacht in zo'n scenario te handelen?
- Wat zijn uw verwachtingen? Waar is dat op gebaseerd?
- Waar denk je recht op te hebben (verwachtingen)? En waar voelt u zich verantwoordelijk voor? **(Bij wie ligt de verantwoordelijkheid: Maatschappelijk/persoonlijk/zorg)**

Q5: Kijk nu opnieuw naar het netwerk dat u heeft geschetst, hoe veranderen de relaties/ verhoudingen die u net beschreef?
- Heeft u het wel eens met mensen uit u sociale kring over veranderingen in ouderenzorg? Of het helpen van elkaar?
- Wat verwacht u van uw netwerk in deze situatie? -> Weten jullie dit van elkaar?
- In hoeverre accepteert u hulp van anderen?
- Wie zijn er betrokken tijdens dit moment?
- Kunt u deze relatie omschrijven? (hoe ervaart u de verhouding?)
- Hoe belangrijk is het dat deze persoon u met dit helpt? En waarom?
- Waar verwacht u dat deze persoon verantwoordelijkheid voor nemen en waarvoor niet?

Scenario 2: *Stel je voor dat u van te voren weet dat het meer op u en uw omgeving aan komt (vanuit de wijk bijvoorbeeld).*

Q6: Hoe zou u zich dan voorbereiden op het moment dat u langdurige zorg nodig zal hebben?
- In hoeverre staat u open voor verandering of hulp die wordt aangeboden?
- Waar voelt u zich verantwoordelijk voor in zo'n verandering?
- In hoeverre bent u nu bezig met voorbereidingen? Waar baseert u dit op?
- Hoe kunt u zich voorbereiden om zelfstandig blijven terwijl u afhankelijker wordt van de ouderenzorg?

4. Uitzoomen naar de betekenis van zorg

Objective: Discover participant's perception on care and how relationships have an influence on this perception. This could be used to indicate their willingness to join the to be determined shift in elderly care. Or could help defining the desired direction of elderly care.

Q7: Wat betekent zorg voor u?
(Metaforen creëren om dit beeld te ondersteunen)
- Waarom is dit zo?
- Wie en wat beïnvloed deze betekenis van zorg jou? (Terug linken aan sociale cirkel)
- Wat vindt u belangrijk in zorg, zowel ontvangen als verlenen?
- Wie is er volgens u verantwoordelijk voor de ouderenzorg?

Q8: Kunt u voorbeelden noemen van hoe de zorg er volgens uw betekenis uit zou zien?
- Welke rol speelt u hier dan in?

Q9: Stel een van uw dierbare belandt, na bijv een heupbreuk, acuut in een langdurige zorgsituatie, wat voor zorg hoopt u dat diegene krijgt, wat is voor u het meest belangrijk?

Care recipient

Introductie

Dank voor uw tijd en bereidheid om deel te nemen aan dit interview. Ik ben Ianthe en [..korte intro]. Ik ben geïnteresseerd naar de waarden die voor u belangrijk zijn in zorgen voor u zelf en zorg ontvangen van anderen, welke verwachtingen er heersen en hoe deze tot stand komen. Ik ben dat, waar woont u?

Dit interview is onderdeel van mijn afstudeerproject en de bevindingen worden gebruikt voor mijn afstudeerverslag.
- Ik zit hier vanuit een neutral rol en ben vooral benieuwd naar uw blik en ervaringen.
- Vindt u het oké als ik dit gesprek opneem, zodat ik de inzichten achteraf goed kan verwerken?
- Achteraf zullen we kort door een toestemmingsformulier doornemen die u vervolgens kan tekenen.
- Als u vragen heeft kunt u die gedurende het hele interview stellen en als u zich op welk moment dan ook wilt terug trekken, dan is dat uiteraard mogelijk.

Dit interview bestaat uit 3 onderdelen
- Algemene vragen -> om begrip te krijgen in uw huidige situatie en weg naar waar u nu bent.
- Inzoomen op een moment van uw dag, het naar bed ga moment. Welke handelingen vinden er plaats en wat vindt u belangrijk tijdens dit moment?
- Uitzoomen en hebben over wat zorg voor u betekend en hoe deze betekenis tot stand komt.

1. Algemeen

Objective: To emphasise with my participants and to enable me to make the questions that will follow more personal.

Q1: Kunt u mij iets over u zelf vertellen? Waarom u hier woont en hoe lang al bijvoorbeeld
- Waar heeft u hiervoor gewoond (eerder al vorm van zorg ontvangen?
- Wat voor beroep heeft u gedaan?
- Leeftijd?
- Naar welke aanleiding bent u hier komen wonen? Wanneer was het opnamemoment, na welk incident?
- Wat is uw huidige fysieke gesteldheid?

2. Inzoomen op het 'naar bed ga moment'

Objective: Identifying values in the context of going to bed (what values play a role in the current way of doing?)

Introduceren: We gaan nu inzoomen op een moment van uw dag, het naar bed ga moment. Met behulp van Playmobile gaan we dit moment samen doorlopen. Ondertussen zal ik vragen stellen over dit moment. Playmobile dient voor het voor het tastbaar maken van de stappen en onderwerpen die we bespreken. Zo kunnen we makkelijk verwijzen naar verschillende mensen die een rol spelen tijdens dit moment.

Q2: Kunt beschrijven waar en wanneer het naar bed ga moment start voor u? (Bijv, moe worden, vaste tijd, signaal van verzorger)

Q3: Kunt u kort omschrijven hoe dit moment stapsgewijs gaat? Vanaf dat u aanstalten maakt totdat u op bed ligt.
- Wat vindt u belangrijk in dit moment?
- Wie zijn er betrokken tijdens dit moment?
- Hoe voelt het wanneer deze persoon uw helpt tijdens dit moment? (Zowel zorgverlenend als emotioneel ondersteunend)
- Kunt u deze relatie omschrijven? (hoe ervaart u de verhouding?)
- Hoe belangrijk is het dat deze persoon u met dit helpt? En waarom?
- Waar wilt deze persoon verantwoordelijkheid voor nemen en waarvoor niet?

Q4: Wat doet u graag zelf tijdens dit moment? En waarom?
- Waarin bent u noodzakelijk afhankelijk van een ander? Waarmee vindt u het fijn om geholpen te worden, wat niet noodzakelijk is?
- In hoeverre geeft u uw voorkeuren aan tijdens dit moment? Wanneer gebeurd dit? Afgesproken tijdens intake al of ter plekken? En verschilt dit per zorgverlener? (Bijv. Eigen bedtijd, wel of niet douchen, tandenpoetsen zelf ja of nee)
- Wat doet het met u als de zorgverlener u aanmoedigt om het zelf te doen en zo lang mogelijk haar handen van iets afhoudt?

3. Inzoomen op het 'naar bed ga moment' in de nabije toekomst

Objective: Identifying and challenge future values in the context of going to bed (what values play a role in the future way of doing?)

Scenario schetsen: Met de de verhoogde druk op de gezondheidszorg poppen er verschillende benaderingen op in hoe we met de vergrijzingspiek en het zorgtekort om kunnen gaan. Hiervan licht ik er graag één uit:

Q5: Wat verwachtte u voordat u hier kwam wonen en komt deze overeen met hoe het nu gaat hier?
- Waar komt deze verwachting vandaan? Waarop of op wie is dit gebaseerd?
- Wat zijn uw verantwoordelijkheden tijdens dit moment? En wie bepaalt dit? Is het duidelijk wat er verwacht wordt van u?
- Merk je verschillen in verwachtingen van u en die van u sociale kring?
- Waar denk je recht op te hebben? En waar voelt u zich verantwoordelijk voor? **(Bij wie ligt de verantwoordelijkheid: Maatschappelijk/persoonlijk/zorg)**

Q6: Hoe heeft u de overgang ervaren van eerder toen u minder afhankelijk was van de zorg naar nu, waarin u afhankelijker bent? Wat doet dit met u?

3. Inzoomen op het 'naar bed ga moment in de nabije toekomst'

Objective: Identifying and challenge future values in the context of going to bed (what values play a role in the future way of doing?)

Scenario schetsen: Met de de verhoogde druk op de gezondheidszorg poppen er verschillende benaderingen op in hoe we met de vergrijzingsgolf en het zorgtekort om kunnen gaan. Zo wordt er langer meer verwacht van uzelf en uw naasten en heeft de dokter minder om u te helpen. Stel je voor: je had geen plek hier, hoe had je dit moment dan anders beleefd? Deels zelf of familie een rol gespeeld. Mening of het zo noodzakelijk is geweest.

Q7: Hoe ziet dan een naar bed ga moment eruit voor u? (Wat veranderd dit in wie u helpt? En op welke manier?)
- Hoe had u dit moment anders beleefd?
- Welke rol speelt u dan zelf? En welke rol speelt de mantelzorger?
- Is alles waarmee u nu bent en wordt geholpen noodzakelijk (geweest)?
- Wat vindt u het belangrijkst in dit moment om te behouden of te veranderen?
- In hoeverre staat u open voor verandering of hulp die wordt aangeboden?
- Waar voelt u zich verantwoordelijk voor in zo'n verandering?

Q8: Hoe veranderen de verhoudingen die u heeft met uw sociale kring?
- Heeft u het wel eens met mensen uit u sociale kring over veranderingen in ouderenzorg? Of het helpen van elkaar?
- In hoeverre accepteer u hulp van anderen?

4. Uitzoomen naar de betekenis van zorg

Objective: Discover participant's perception on care and how relationships have an influence on this perception. This could be used to indicate their willingness to join the to be determined shift in elderly care. Or could help defining the desired direction of elderly care.

Q9: Wat betekent zorg voor u?
(Metaforen creëren om dit beeld te ondersteunen)
- Waarom is dit zo?
- Wie en wat beïnvloed deze betekenis van zorg jou? (Terug linken aan sociale cirkel)
- Wat vindt u belangrijk in zorg, zowel ontvangen als verlenen?

Q10: Kunt u voorbeelden noemen van hoe de zorg er volgens uw betekenis uit zou zien?

Q11: Stel een van je dierbare belandt, na bijv een heupbreuk, acuut in een langdurige zorgsituatie, wat voor zorg hoop je dat diegene krijgt, wat is voor jou het meest belangrijk?

Afronding

- Wil je nog iets meegeven voor dit project?
- Heb je nog andere vragen?
- Ben je geïnteresseerd om verder in dit project nog een keer deel te nemen aan een onderzoek? Mogelijk voor validatie?
- Hartelijk dank voor je tijd. Als je het leuk vindt deel ik aan het eind van dit project mijn verslag met jou.
- Toestemmingsformulier doorlopen

Gegeven- ZZP4 afwijzen, betekent dat je zwaardere cliënten behandelt in dezelfde tijd als je nu doet. Zwaardere taken en niet meer tijd of meer handen…..

Q8: Op welke manier merkt je deze druk nu al?
- In welke mate merk je de vergrote druk op zorg en noodzaak om onder tijdsdruk te werken en het de client meer zelf te laten doen?
- Hoe kijkt u nu naar de rol van u als zorgverlener? En hoe is dat in relatie tot de rest van Nederland (mantelzorger, overheid etc)?

Q9: Hoe ziet dan een naar bed ga moment eruit voor jou? (Wat veranderd dit in wie er helpt? En op welke manier?)
- Wat vind je het belangrijkst in dit moment om te behouden of te veranderen?
- In hoeverre sta je open voor verandering of hulp die jij kan bieden of die over wordt genomen door anderen?
- Waar voelt jij je verantwoordelijk voor in zo'n verandering?

Q10: Indien er van jou verwacht wordt dat je minder zorg levert, op welke manier communiceer je dit aan de client en naasten? (Vanuit de gedachte: zelf als het kan, digitaal als het kan…)
- Wat voor reactie krijg je dan?
- Welk gevoel geeft het jou om dit gesprek te moeten voeren?

4. Uitzoomen naar de betekenis van zorg

Objective: Discover participant's perception on care and how relationships have an influence on this perception. This could be used to indicate their willingness to join the to be determined shift in elderly care. Or could help defining the desired direction of elderly care.

Q10: Wat betekent zorg voor jou?
(Metaforen creëren om dit beeld te ondersteunen)
- Waarom is dit zo?
- Wie en wat beïnvloed deze betekenis van zorg jou? (Terug linken aan sociale cirkel)
- Wat vind je belangrijk in zorg, zowel in ontvangen als verlenen?

Q11: Stel een van je dierbare belandt, na bijv een heupbreuk, acuut in een langdurige zorgsituatie, wat voor zorg hoop je dat diegene krijgt, wat is voor jou het meest belangrijk?

Q12: Kan je voorbeelden noemen van hoe de zorg er volgens jouw betekenis uit zou zien?
- Welke rol speelt de verzorger in het creëren hiervan?

Afronding

- Wil je nog iets meegeven voor dit project?
- Heb je nog andere vragen?
- Ben je geïnteresseerd om verder in dit project nog een keer deel te nemen aan een onderzoek? Mogelijk voor validatie?
- Hartelijk dank voor je tijd. Als je het leuk vindt deel ik aan het eind van dit project mijn verslag met jou.

Introductie

Dank voor uw tijd en bereidheid om deel te nemen aan dit interview. Ik ben Ianthe en [..korte intro]. Ik ben geïnteresseerd naar de waarden die voor jou belangrijk zijn in het zorgen voor anderen, op welke manier dit momenteel gebeurd en waar jij je voldoening uit haalt. Verder ben ik benieuwd naar jouw blik op de zorg en welke verwachting er heersen vanuit jou, de ouderenzorg en de zorgvrager.

Dit interview is onderdeel van mijn afstudeerproject, wat eind februari gepresenteerd zal worden op de TU Delft.

- Ik zit hier vanuit een neutrale rol en ben vooral benieuwd naar uw blik en ervaringen.
- Vindt u het oké als ik dit gesprek opneem, zodat ik de inzichten achteraf goed kan verwerken?
- Achteraf zullen we kort door een toestemmingsformulier doornemen die u vervolgens kan tekenen.
- Als u vragen heeft kunt u die gedurende het hele interview stellen
- Als u zich op welk moment dan ook wilt terug trekken, dan is dat uiteraard mogelijk.

Dit interview bestaat uit 3 onderdelen

- Algemene vragen -> om begrip te krijgen in uw huidige situatie en wat uw bezigheden in mantelzorgen en daarnaast.
- Inzoomen op een moment van uw dag, waarin uw mantel helpt. Welke handelingen vinden er plaats en wat vindt u belangrijk tijdens dit moment?
- Uitzoomen en hebben over wat zorg voor u betekend en hoe deze betekenis tot stand komt.

Voordat we starten, wil je nog iets kwijt of heb je nog vragen?

1. Algemeen

Objective: To emphasise with my participants and to enable me to make the questions that will follow more personal.

Q1: Kan je mij iets over u zelf vertellen? Wat doet u in het dagelijks leven?

- **(Als de persoon actief is bij Surplus)** Kunt u kort beschrijven wat uw verantwoordelijkheden zijn in uw huidige functie en wat voor handelingen hierbij komen kijken? (Hoe ziet een werkweek eruit?)
  - Wat vindt u leuk aan uw werk? Wat maakt u blij?
- Leeftijd?

Q2: Hoe bent u in de mantel positie gekomen?

- Vanaf wanneer bent u actief als mantelzorger? Hoe is dit tot stand gekomen?
- Zijn er nog anderen personen of partijen die ondersteunen in deze situatie?
- In hoeverre voelt u verantwoordelijkheid om deze rol op u te nemen?
- Met wie bent u in contact over gezondheidszaken mbt tot uw zorgvrager?

2. Inzoomen op een verzorgingsmoment

Objective: Identifying values in the context of one specific situation of caregiving (what values play a role in the current way of doing?)

Introduceren: Ik wil graag met u inzoomen op een moment van de dag, waarin u de zorgvrager verzorgd. Kunt u een voorbeeld noemen van waarmee u de zorgvrager regelmatig helpt?

Q3: Kunt u kort stapsgewijs omschrijven hoe dit moment eruit ziet? Vanaf dat u start met de voorbereidingen.

- Wat vindt u belangrijk tijdens dit moment, zowel voor uzelf als voor de zorgvrager?
  - Wat is er voor u nodig om deze dingen zo goed mogelijk uit te voeren?
    - **Door wie** moet dit geregeld worden?
- Hoe voelt het wanneer u de zorgvrager helpt tijdens dit moment?
  - Hoe ervaart u de verhouding met uw zorgvrager? Kunt u de band omschrijven?

4. Uitzoomen naar de betekenis van zorg

Objective: Discover participant's perception on care and how relationships have an influence on this perception. This could be used to indicate their willingness to join the to be determined shift in elderly care. Or could help defining the desired direction of elderly care.

Q9: Wat betekent zorg voor u?
(Metaforen creëren om dit beeld te ondersteunen)

- Waarom is dit zo?
- Wie en wat beïnvloed deze betekenis van zorg jou? (Terug linken aan sociale cirkel)
- Wat vindt u belangrijk in zorg, zowel ontvangen als verlenen?
- Wie is er volgens u verantwoordelijk voor de ouderenzorg?

Q10: Kunt u voorbeelden noemen van hoe de zorg er volgens uw betekenis uit zou zien?

- Welke rol speelt u hier dan in?

Q11: Stel een van uw dierbare belandt, na bijv een heupbreuk, acuut in een langdurige zorgsituatie, wat voor zorg hoopt u dat diegene krijgt, wat is voor u het meest belangrijk?

Afronding

- Wil je nog iets meegeven voor dit project?
- Heb je nog andere vragen?
- Ben je geïnteresseerd om verder in dit project nog een keer deel te nemen aan een onderzoek? Mogelijk voor validatie?
- Hartelijk dank voor je tijd. Als je het leuk vindt deel ik aan het eind van dit project mijn verslag met jou.

Q4: Wat is noodzakelijk om mee te helpen en waar helpt u de zorgvrager graag mee?

- Hoe gaat u om met voorkeuren van de zorgvrager? Hoe vindt dit gesprek plaats en waar? Is er sprake van een wisselwerking?
- Wat verwacht u van zichzelf in dit moment? En kunt u deze verwachting waarmaken?

Q5: Zijn er nog anderen personen betrokken tijdens dit moment? (Denk ook aan voorbereiding, wat regelen naasten, kleding en inrichting bijv)

- Hoe is het contact met deze personen?
- Kunt u de relaties en verhoudingen met deze personen omschrijven? (Intensity/power related)
- Wat vindt u belangrijk in de verschillende relaties?
- Hangt er een verwachting vanuit uw omgeving over hoe en dat u moet mantelzorgen?
  - Waar komt deze verwachting vandaan? Waarop of op wie is dit gebaseerd denk je?
- Merk je verschillen in verwachtingen tussen u en de personen die u net omschreef?
- In hoeverre speelt Surplus als organisatie een rol in het verlenen van mantelzorg?
- Is er een bepaalde soort begeleiding nodig?

Q6: Waar haalt u momenteel voldoening uit? -> waar op de dag, zijn er bepaalde tastbare momenten?

- Aan welk deel van je werk haal jij het meest voldoening (zo ook tijdens het naar bed ga moment) ?
- Los van mantelzorg, maar als Surplus rol: Wat vind je belangrijk tijdens je werk, wat stelt u in staat om deze belangrijke punten uit te kunnen voeren? (Wat is hier voor nodig vanuit organisatie en anderen?)

3. Inzoomen op het verzorgingsmoment in de nabije toekomst

Objective: Identifying and challenge future values in the context of going to bed (what values play a role in the future way of doing?)

Scenario schetsen: Met de de verhoogde druk op de gezondheidszorg poppen er verschillende benaderingen op in hoe we met de vergrijzingspiek en het zorgtekort om kunnen gaan. Hiervan licht ik er graag één uit:
Stel je voor dat……

Gegeven- ZZP4 afwijzen, betekend dat men langer thuis blijft en er mogelijk meer verwacht wordt van mantelzorger.

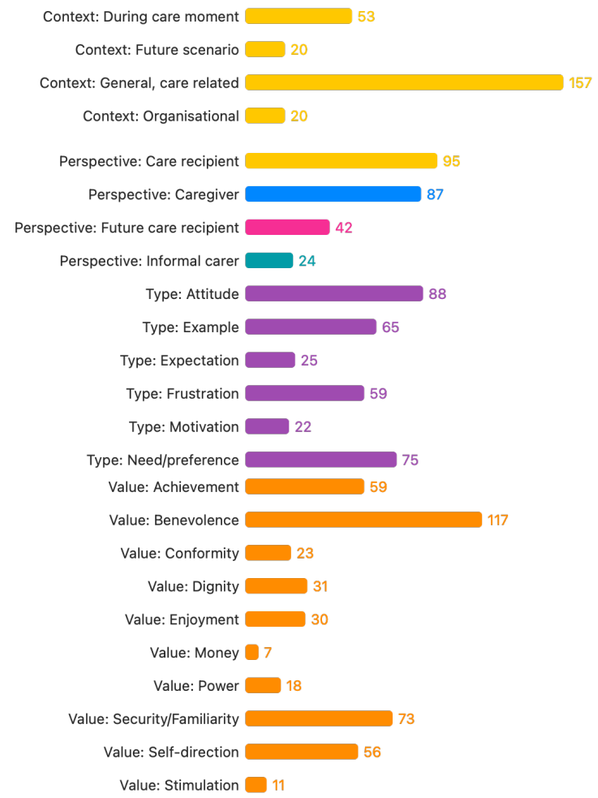
Q7: Op welke manier merkt u dit nu al en zal u dit merken?

- In welke mate merk je de vergrote druk op zorg en noodzaak om het meer zelf te laten doen waar mogelijk?
- Hoe kijkt u nu naar de rol van u als mantelzorgers? En hoe is dat in relatie tot de rest van Nederland?
- Wie is er verantwoordelijk om dit op te vangen?
- Wat vindt u het belangrijkst in dit moment om te behouden of te veranderen?
- In hoeverre staat u open voor verandering of ondersteuning van anderen middelen of personen?
- Waar voelt u zich verantwoordelijk voor in zo'n verandering?

Q8: Wat is er voor nodig om de druk op de zorg op te vangen als mantelzorger?

- Hoe wordt je momenteel zowel qua vaardigheden als mentaal gesteund en door wie? (Respijtzorg)
- Op welke manier moet deze boodschap overgebracht worden naar mantelzorgers en door wie?
  - Op welke manier zou u toekomstige mantelzorgers voorbereiden om lange zorg periode waarin meer van hen verwacht wordt?

2. Codebook for data analysis of uncovering values



3. Values and its definitions as adopted for this research

HUman values

I applied Schwartz's theory to define human values are defined (2012). Through an iterative coding process, I refined some values for better applicability to this study. Additionally, while coding, I formulated definitions of the values based on Schwartz's theory, other references and added study-specific examples for clarification and to limit ambiguous interpretation.

Self-direction

Refers to being able to think and do things by yourself. It is about choosing, creating and exploring independently, driven by the desire for control and mastery.

<u>In this context:</u> Wanting to do things independently as long as possible, and is closely linked to being self-reliant.

- Creativity
- Independent
- self-reliance
- Autonomy
- Freedom
- Control
- Ownership

Stimulation

Wanting to keep on learning and exploring, driven by the need for variety, adventure and challenges in life.

<u>In this context</u>: Staying active in exploring new things and challenge yourself, for example learn how to paint at daycare activities or learning to work and think in new ways.

- Keep on learning
- Varied life
- Excitement
- Optimism
- Trainings
- Learning on how to do things differently

Enjoyment

This is all about the pursuit of pleasure and experience of joy (hedonism). It involves a sense of happiness or fulfilment, for example tyhrough fun, laughter or receiving appreciation.

<u>In this context:</u> Like a having a laughter in a chat with care recipient and care giver or in relation to job satisfaction or receiving thanks for those you have care for.

- Pleasure
- Enjoying life
- Fun and laughter
- Self-indulgent
- Joy
- Company
- Appreciation/rewarding
- Sensory gratification (intimacy,sound,visual etc)
- Emotional gratification

Achievement

Refers to the personal pursuit of success and actively demonstrating competence according to social standards.

<u>In this context:</u> Being ambitious in work or life, striving for effectiveness such as providing optimal care even under time constraints. Or think of the appreciation expertise and profesionality, whether it comes from the care recipient towards the caregiver or among caregivers.

- Profesionality
- Ambitious
- Successfull
- Influential
- **Time efficient (conflicting with bevolance -> empathy)**
- Competence
- **Dependability**
- Wanting to work together to acheive more
- Collaboration to achieve more or be more effective
- Not meeting expectationss anymore

Power

Refers to social status, control or dominance over people and resources. This involves the ability to influence, guide thoughts, behaviours, or decisions of others within a social context. Unlike the achievement value it focusses on the preservation of a dominant position within the more general social system.

<u>In this context</u>: Think of comparing among caregivers due to differences in education, or hierarchy in health sector. Also, consider the demonstration of authority from caregiver towards care recipient or organisation.

- Dominance
- **Control**
- **Authority**
- **Status/image**
- Equality in salary/ differences in status
- Zeggenschaptonen
- Hierarchy
- Role changes on workplace, doing thing tot function related

Security, familiarity

Encompasses safety, harmony, and stability of society, relationships, and oneself.

In this context: A secure home and working environment (with good mental and physical health). It is about valuing familiar things that evoke a sense of safety, warmth and ease. Or think good working conditions for caregivers or hygiene and a healthy diet for care recipients.

- Safety
- Clean
- Trust
- Harmony and stability
- Familiarity
- Sticking to habits
- Physical safety (e.g. challenged by heavier and more demanding care recipients)
- Mental health (e.g. under pressure with time pressuer)
- Safe feeling when people look after you
- Secure working environment
- **Transparency in waiting time**

Benevolence (liefdadigheid)

Herein someone prioritises the welfare of others and has a genuine desire to contribute positively to the lives of those around them without expecting anything in return. It is often associated with kindness, understanding, empathy, and acts of generosity.

<u>In this context:</u> It can refer to empathising with the care recipient or caregiver by actively trying to understand each other. For example, a care giver invests effort in understanding the preferences and capabilities of the care recipient, adapting their accordingly. It is also evident in the obviousness of caring for one's family.

- Helpful
- Kindness
- Loyal/honest
- Affiliation
- Empathy
- Obviousness of care for family
- Forgiving
- Looking out for each other
- Shared decision making with client, doing it together
- Good will/ compassion
- Togetherness
- Keeping into account one's preferences
- Act with care (considered and calm, which is under pressure when caregiver needs to hurry)

Conformity

A social behaviour in which someone adjusts their thoughts, beliefs, attitudes, or behaviour to align with the prevailing norms, values, or expectations of a group or society. It involves adhering to established social standards to fit in or be accepted by others.

<u>In this context:</u> For example, care recipients entering a care home might allow tasks that they are still capable of performing independently to be taken over because it seems easier to conform to prevailing practices. This can. lead to a gradual adjustment in behaviour to align with the established norms within the facility. Or think of feeling hesitant to ask for help because the other person seems busy and you don't want inconvenience others.

- code of conduct, which could constraints you
- Conformity to social expectations
- Reserved, privacy
- Not asking for help due to social standards (kids are busy with their own kids)
- Feeling burdened
- Acceptance, take things the way they are. Social change, and citizens have to accept it.
- Vanuit een verwachting van anderen andelen
- Obedient
- Politeness

Dignity

The inherent worth and respect owed to every individual, regardless of their background, characteristics, or circumstances. It involves treating others with respect and safeguarding their rights. In contrast to, conformity, which refers more to persons with whom one frequently interacts (family, nurse), dignity refers to more abstract object such as religion and rights.

<u>In this context:</u> Seeing the human in each individual and honouring one's autonomy, rituals and preferences.

- Respect for tradition
- Respect
- Commitment
- Wisdom
- Tolerance
- Mens is geen kamernummer
- Mens in de mens zien
- Mutual respect
- Not blaming nurses for societal problems.
- Fairness, justice
- Seeing the human as a individual
- Equality

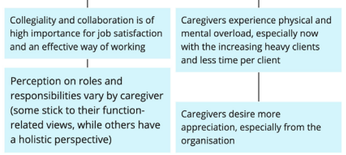
Money

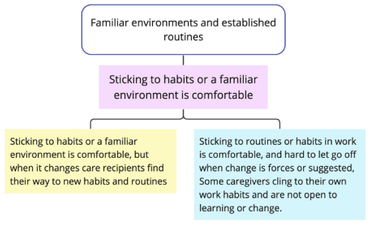
In contrast to a human value, money is perceived as a economic value, which according to Boztepe refers to the economic benefits something has (2007).

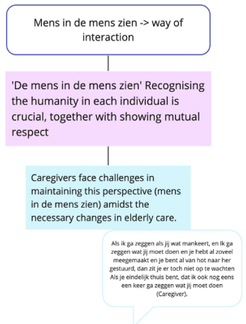
In this context it is about the financial aspect of receiving and providing care, which way be related to the care people expect to receive, while they payed for it (directly, or indirectly via insurance or taxes). Additionally is can refer to differences in salary between caregivers.

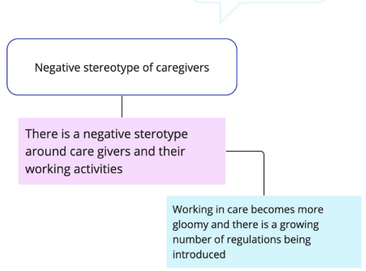
- Salary differences
- Affordability of care
- Insurance
- Expected care in return for money
- Reimbursed care and the associated care with it (ZVW)

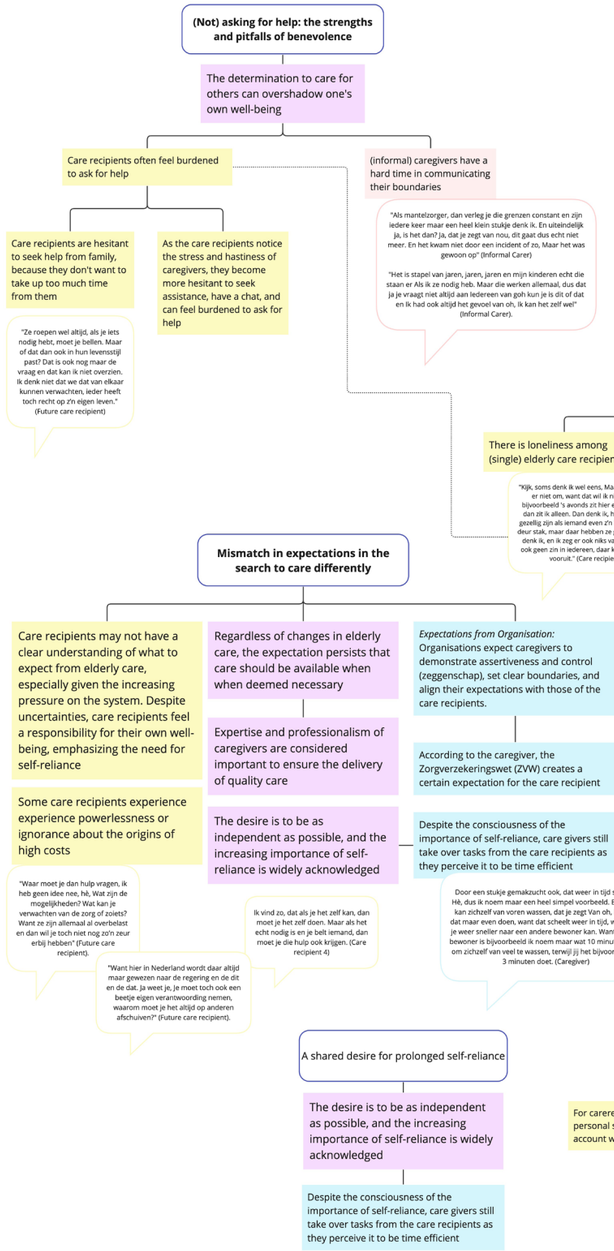
4. Nine emerged themes explained



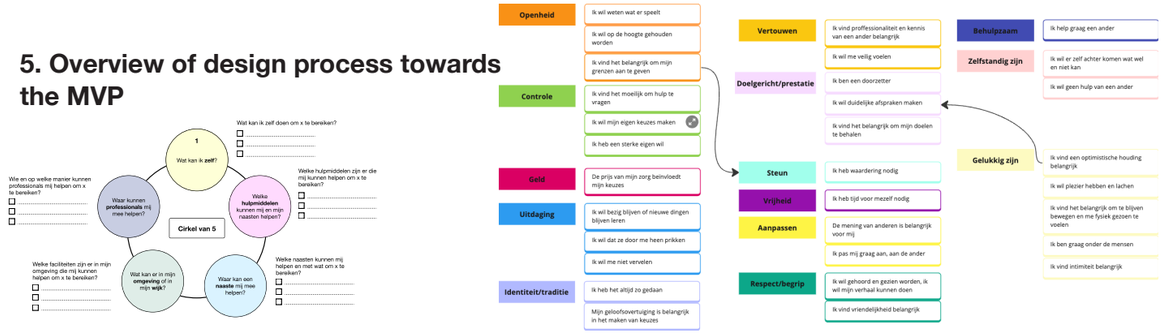


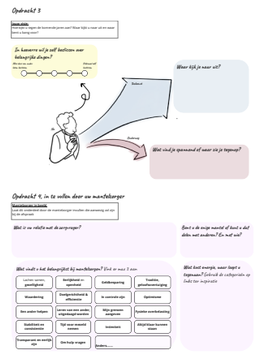


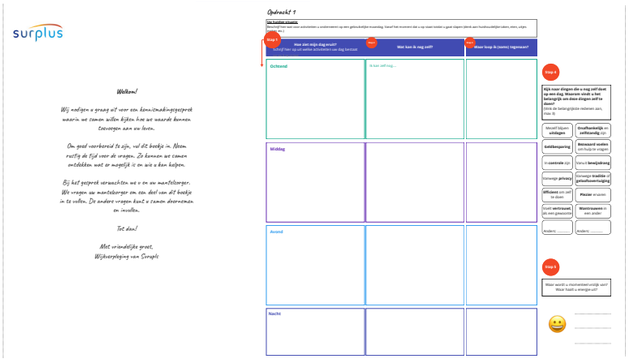


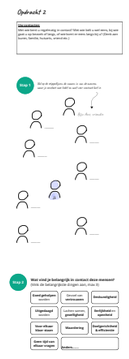


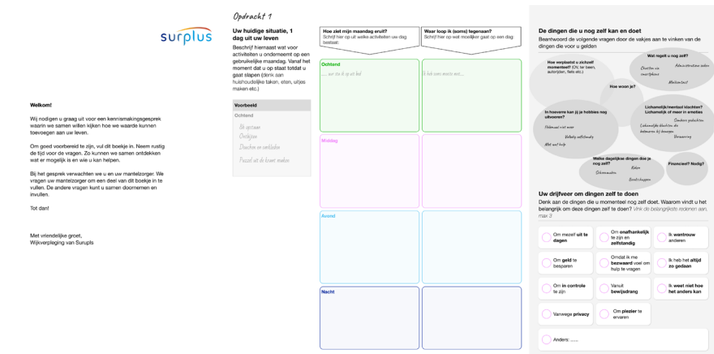
5. Overview of design process towards the MVP





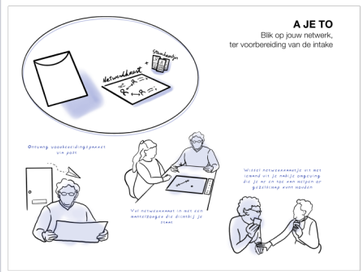






6. Three concept ideas pitched to the roject team 'Intake 2.0'

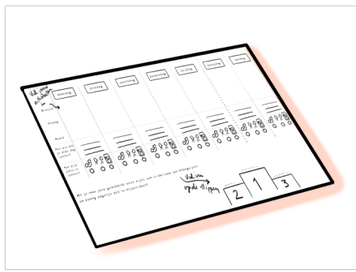
In preparation for the intake



Concept 1: A JE TO, Networking and expressing motivations to help each other

- Uncovering shared values and expressing mutual commitment: What's in it for you, what's in it for me?
- Prior to the intake the care recipient is asked to reach out to 2-3 relatives (potential or current informal carers)
- **During the conversation:** Supplementing this network map with resources from Surplus

(assignment from Surplus to care recipient, to encourage them to take the first step in asking for help in their social circle or neighbourhood)

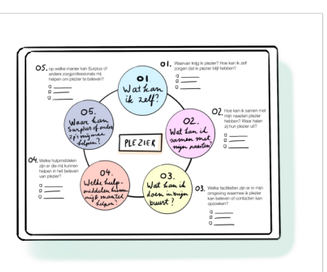


Concept 2: Reflection on your daily life

- How does your week look like, what challenges are you facing, what are you still capable of doing yourself, and why is this important to you?
- **Goal:** To encourage clients to reflect on their current lives and familiarise them with value-related questions.
- **During the conversation:** If you become more dependent on care, this may no longer be possible, but how do we ensure that what you find important in this regard will be fulfilled in another way?

(assignment from Surplus to care recipient, to fill out in advance)

During the intake



Concept 3: Value-based circle of five

- Identify the care recipient's core values and develop a plan to maintain them using the Circle of 5. For instance: How does your social network enhance your happiness (who do you enjoy interacting with)? As you explore these 5 aspects, expectations are articulated and potential roles and opportunities become clearer.

Design sub-questions

In broad terms, describing what the input and output of the design should be and how the two concepts support each other.

Additionally, it shows design questions to be answered apart from the interaction questions supporting the design statement. The following questions focus more on the practicality of the design in stead of the intended emotions or interactions that the design should evoke.

7. Desired input and output of the two chosen concepts

Preparation involvement (who to involve)
Q1: Should the client and informal carer engage in joint preparation activities, or should they have separate exercises?
Q2: Is the informal carer's involvement limited to the actual meeting, or are there other stages where they should participate?

Communication clarity:
Q1: How can we clearly communicate the purpose of the preparation exercise?
Q2: How can we effectively articulate the intention of the meeting, ensuring that clients and their informal carer are not surprised during the intake?

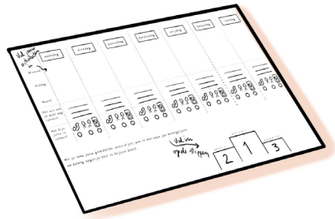
Encouraging completion and honesty
Q1: How can we structure the preparation process to ensure completeness?
Q2: How do we design the tool to encourage users to provide genuine responses? (And how can we mitigate the tendency of some clients to provide desired but inaccurate information to receive preferred help or care?)

Distribution Method:
Q1: In what ways can the preparation tool be distributed - digitally, in print, or both?
Q2: How can we design for flexibility to be able to address diverse needs and capabilities of users?

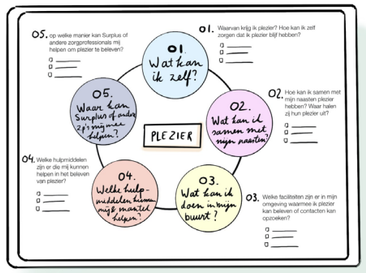
Data processing:
Q1: How can Surplus process the data collected from the conversation tool and who should do this?

Accessibility management:
Q1: Who should have access to the tool and what is the desired authorisation per involved person (editor, viewer, reactions) (This could change over time and could depend on the relation and privacy preferences of client and informal carer)
Q2: How can we enable access and changes in authorisation levels to the tool to facilitate adjustments when needed?

Name of meeting moment:
Q1: How can we name this conversation so that it covers the purpose of the meeting and thus manage expectations beforhand?
Replace intake by something else so that expectations beforehand are managed



How to link these?



Crucial information during the meeting:
Q1: What crucial information or questions should be addressed during the first conversation, and can they all be covered within the applied circle of five?

Motivation and Guidance:
Q1: How do we motivate users to consistently use and update the conversation tool at home?
Q2: What type of guidance is necessary, and from whom, to support users in effectively utilising the tool outside of the meeting moments with the caregiver?

Autonomy focus:
Q1: How do we ensure that autonomy remains a central throughout the entire contact between client and Surplus?
Q2: How can we enable adaption and adjustments on level of autonomy based on evolving needs and circumstances?

Standardising Participant Values:
Q1: In what ways can we standardise the values or things that the participant considers important, so that during the meeting, caregiver can assess which topics or values need to be discussed based on the preparation?

Q2: What methods can be employed to standardise the identification of participant values, aiding caregivers in making informed assessments of relevant topics during the meeting process?

Input

For Surplus:
- Scheduled meeting for intake
- Send out preparation exercise with the invitation for the intake
- Checking with client if they are capable to participate in this type of preparation and intake and decide on whether they are suitable for this type of intake (e.g. can they read, write, are digitally skilled, or do they have an informal carer who can offer help, do they have informal carer to join intake?)

For Client:
- Receiving invitations with instructions on preparation exercise
- Inviting informal carer to participate in preparation

For informal carer:
- Getting invited by either client or by Surplus to join intake and help with preparation

During use

For Surplus:
-

For Client:
- Knowing what to do and why
- Easy to complete the tasks
- Consciousness that it is important to fill it out truthfully and is necessary to do prior to intake

For informal carer:
- Knowing what there role is in preparation for the intake

Goal: sensitise client with value based questions, talking in what they find important instead of what pain they want to get rid of. Think of purpose, gains and pains in life

- Current situation
- View on coming period/years ahead
- What they find important and when
- What they expect from each other
- Practical information to spare time during intake

Output

For Surplus:
- Overview on what the user finds most important and to what extend it is important to them. (Knowledge and physical/tangible overview)
- Honest image of clients view on what they find important

For Client:
- Sense of awareness on what is important to them in daily live and how they look forward to coming years.
- Knowing what to expect from the intake
- Understanding why Surplus makes them prepare for the intake in this way

For informal carer:
- 1st sense of that they will play an important role in the next steps of caring and a sense that they can bring input in as well and hat this is necessary/valuable input.

Input

For Surplus:
- Guidelines for intake
- Necessary materials for intake

For Client:
- Results of preparation exercise
- Capability to talk about what they find important
- Know-how and expectation on what the goal is of the intake

For informal carer:
- Aware of the importance on there presence during the intake

During intake

For Surplus:
- Leading the conversation
- Clearly explaining the reason why they do it like this
- Helping the attendees to come loose and feel supported
- Filling in the form together with attendees
- Expressing expectations towards each other

For Client:
- Active participation
- Understanding why they do this and how
- Expressing expectations towards each other

For informal carer:
- Active participation
- Understanding why they do this and how
- Expressing expectations towards each other

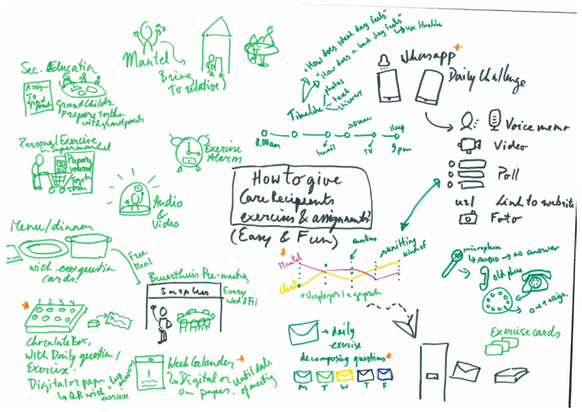
-Space for life story
-Daily care
-Daily joy
-Expressing expectations about the next steps

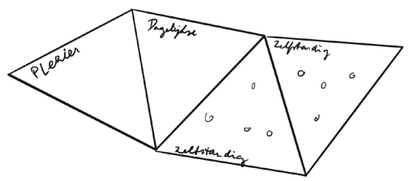
Output

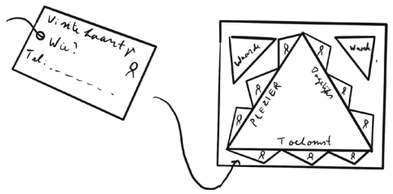
For Surplus:
- Form of client to process digitally in client administration program
- Specific action points that are raised during the intake

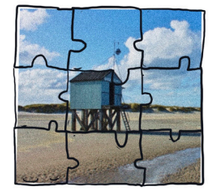
For Client:
- Copy of there personal overview or knowing how to access it when they leave intake
- Knowing what they can start doing or can undertake to support themselves
- Knowing what to expect from whom

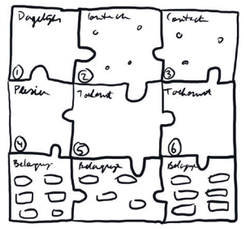
For informal carer:
- Copy of there personal overview or knowing how to access it when they leave intake
- Knowing there responsibilities in care for client
- Confidence in how to proceed or where to ask for help if necessary

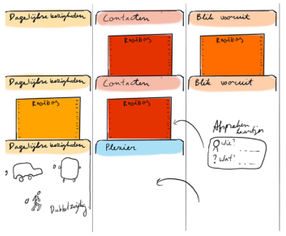


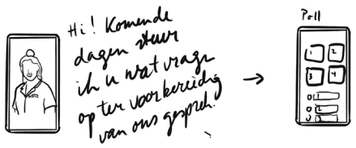




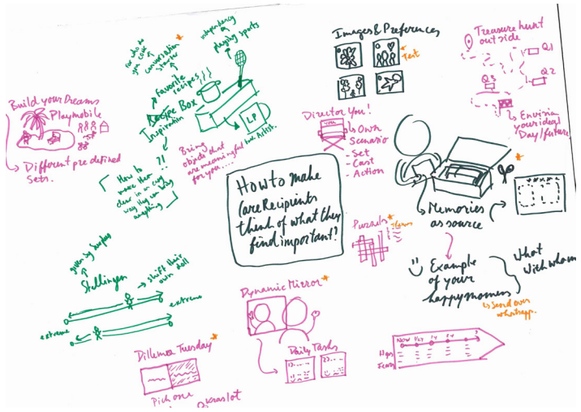


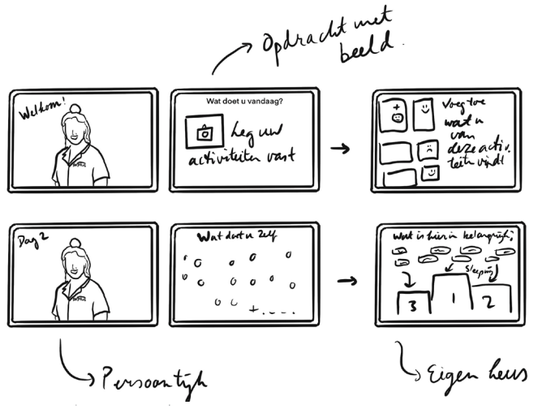


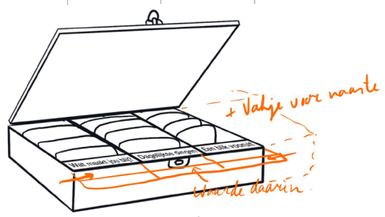




8. Design iterations from MVP to T-Doos







9. MVP: Prepatory booklet

Booklet for informal carer

"Deze folder is bedoeld voor uw naaste als deze soms voor u zorgt. Als u gee naaste heeft die voor u zorgt, hoeft u deze folder niet in te vullen."

Beste [naam mantelzorger],

We leren u ook graag kennen! Aangezien er steeds meer van mensen wordt gevraagd rondom kwetsbare ouderen, vinden wij het belangrijk om samen te ontdekken wat er mogelijk is en te bespreken wat voor u belangrijk is bij de zorg voor uw naaste. Graag nodigen we u uit om deel te nemen aan een kennismakingsgesprek met uw naaste, die extra hulp nodig heeft.

Voor een goede voorbereiding van ons gesprek vragen wij u vriendelijk de vragen op de achterkant van deze folder in te vullen. Neem rustig de tijd voor de vragen.

Bij het gesprek verwachten we zowel u als uw naaste, zodat we samen kunnen kijken hoe we waarde kunnen toevoegen aan het leven van uw naaste.

Wij kijken er naar uit om met uw kennis te maken!

Met vriendelijke groet,

Betina,
Wijkverpleger bij Surplus

Uw afspraak

Datum: **maandag 29 januari, om ...uur**
Adres: **.....**
Duur gesprek: **ongeveer 1 uur**

Als u verhinderd bent en de afspraak wilt annuleren of wijzigen, dan kunt u dat doorgeven aan onze balie op 06.....

Wat vindt u belangrijk in het zorgen voor uw naaste?

Wat is uw relatie met degene waarvoor u zorgt?

Bent u de enige die voor uw naaste zorgt of kunt u dat delen met anderen? En met wie?

Wat vindt u belangrijk als u in contact bent met uw naaste?

In het contact met mijn naaste vind ik het belangrijk om/dat....

Gebruik de voorbeelden om te helpen:

- ☐ **Begrip:** gehoord en gezien worden
- ☐ **Elkaar uitdagen**
- ☐ **Waardering geven en krijgen**
- ☐ **Intimiteit**
- ☐ **Gezelligheid:** plezier hebben
- ☐ **Controle:** eigen keuzes maken
- ☐ **Optimisme**
- ☐ **Stabiliteit:** weinig veranderingen
- ☐ **Veilig voelen**
- ☐ **Professionaliteit en expertise**
- ☐ **Open en eerlijk zijn**
- ☐ **Rekening houden met geloofsovertuiging**
- ☐ **Elkaar de ruimte geven**
- ☐ **Duidelijke afspraken maken**
- ☐ **Niet te veel tijd vragen van een ander**

Hoe ervaart u de zorg nu en wat zijn uw verwachtingen?

Wat kost energie, waar loopt u tegenaan?

Door het zorgen voor mijn naasten merk ik dat....

Gebruik de voorbeelden om te helpen:

- ☐ **Moeite met hulp vragen aan anderen**
- ☐ **Mijn eigen grenzen aangeven**
- ☐ **Goed communiceren is moeilijk**
- ☐ **Weinig tijd voor mijn eigen leven**
- ☐ **Fysieke klachten**
- ☐ **Ik voel schaamte**
- ☐ **Moeilijk te combineren met mijn werk**
- ☐ **Ik voel veel druk om zorg te dragen**
- ☐ **Ik wil controle houden:** moeilijk iets uit handen te geven

Wat verwacht u van Surplus? Wat denkt u nodig te hebben van hen?

Uw kladblok

Voor al uw notities en vragen die u heeft om te bespreken in het kennismakingsgesprek

Dit kladblok kunt u vrij gebruiken.

Is er bijvoorbeeld nog iets wat u van Surplus wilt weten?

Welkom .....

Wij nodigen u graag uit voor een kennismakingsgesprek waarin we samen willen kijken hoe we waarde kunnen toevoegen aan uw leven.

Om goed voorbereid te zijn, vul dit boekje in. Neem rustig de tijd voor de vragen. Zo kunnen we samen ontdekken wat er mogelijk is en wie u kan helpen. Ook zit er een klein boekje bij voor uw naaste die ook bij het gesprek aanwezig zal zijn.

Wij kijken er naar uit om met uw kennis te maken!

Tot dan!

Met vriendelijke groet,

[Naam],
Wijkverpleger bij Surplus

[foto wijkverpleger]

Uw afspraak

Binnenkort komt [naam] bij u langs voor een kennismakingsgesprek.

Datum: **, om ..... uur**
Adres: **.....**
Duur gesprek: **ongeveer 1 uur**

Als u verhinderd bent en de afspraak wilt annuleren of wijzigen, dan kunt u dat doorgeven aan onze balie op 06.....

Waarom deze voorbereiding?

We willen u graag beter leren kennen! Met de drukte in de zorg wordt er veel van u en uw naasten gevraagd. Daarom is het belangrijk om op tijd samen te bekijken wat er mogelijk is voor uw specifieke situatie. Om uw situatie goed te begrijpen, willen we weten hoe uw dagelijks leven eruitziet, wat u nog zelf kunt doen en hoe u naar de toekomst kijkt.

Vul dit boekje in en neem het mee naar ons kennismakingsgesprek. Dan kunnen we samen praten over hoe we de dingen die u blij maken kunnen behouden en rekening kunnen houden met wat belangrijk is voor u en uw familie.

In het gesprek is er tijd voor uw verhaal en beantwoorden we graag uw vragen. Deze voorbereiding is belangrijk, zodat we tijdens het gesprek concrete plannen kunnen maken. Zo weten straks u, uw naaste en wij van Surplus hoe we actief kunnen werken aan het verbeteren van uw situatie.

Is er iets wat u kwijt wilt van te voren? Wat is de reden dat u een kennismakingsgesprek heeft ingepland?

Persoonlijke gegevens

Probeer zoveel mogelijk alvast in te vullen, dan hebben we zo meer tijd tijdens onze kennismaking om te kijken wat er mogelijk is

Volledige naam: _____
Telefoonnummer: _____
Mailadres: _____
BSN: _____
Naam van uw huisarts: _____
Naam van uw apotheek: _____
Naam van uw zorgverzekering: _____
Naam van uw eerste contactpersoon _____
Telefoonnummer eerste contactpersoon: _____
Mailadres eerste contactpersoon: _____

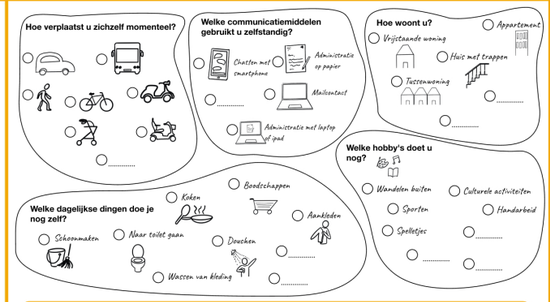
Wat heeft u gisteren gedaan? 1

Schrijf hier op uit welke activiteiten uw dag bestaat:

Hoe zag gister er uit voor mij? Schrijf hier op uit welke activiteiten uw dag bestaat:	**Waar loop ik (soms) tegenaan?** Schrijf hier op wat moeilijker gaat op een dag:
Ochtend *..... toen ik op uit bed*	*Ik heb eens moeite met.....*
Middag	
Avond	
Nacht	

Welke dingen kan en doet u nog zelfstandig? 2

Beantwoord de volgende vragen door de rondjes in te kleuren van de dingen die voor u gelden



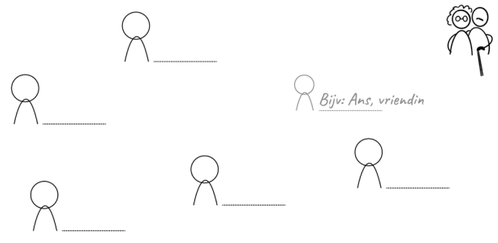
Waarom is het voor u belangrijk om zelf dingen te blijven doen?

Ik vind het belangrijk om zelfstandig te blijven omdat...

Kunt u zich herkennen in de volgende stellingen? (kleur de cirkel in)

	nee	een beetje	ja
1. Ik wil zelfstandig blijven omdat ik altijd alles zelf heb gedaan, ik voel me verantwoordelijk om dat zelf te doen.	○	○	○
2. Ik wil zelfstandig blijven omdat ik geen hulp en tijd wil vragen aan anderen; ik voel me bezwaart.	○	○	○
3. Ik wil zelfstandig blijven vanwege mijn geloof.	○	○	○
4. Ik wil zelfstandig blijven omdat ik het lastig vind om om dingen aan anderen over te laten en zelf graag de controle houd.	○	○	○
5. Ik wil zelfstandig blijven om mezelf steeds uit te dagen.	○	○	○

Wie zijn op dit moment uw vaste sociale contacten? Denk hierbij aan vrienden, familie, mensen uit de buurt. 3



Wat vindt u belangrijk als u in contact bent met deze personen?

In het contact met mijn sociale contacten vind het het belangrijk om/dat....

Gebruik de voorbeelden om te helpen:

- ☐ **Begrip:** gehoord en gezien worden
- ☐ **Elkaar uitdagen**
- ☐ **Waardering geven en krijgen**
- ☐ **Intimiteit**
- ☐ **Gezelligheid:** plezier hebben
- ☐ **Controle:** eigen keuzes maken
- ☐ **Optimisme**
- ☐ **Stabiliteit:** weinig veranderingen
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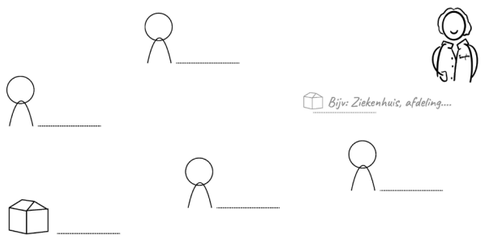
- ☐ **Open en eerlijk zijn**
- ☐ **Rekening houden met geloofsovertuiging**
- ☐ **Elkaar de ruimte geven**
- ☐ **Duidelijke afspraken maken**
- ☐ **Niet te veel tijd vragen van een ander**

Wie zijn op dit moment uw vaste professionele contacten? 4

Denk hierbij aan personen of organisaties zoals een gehoorarts of huisarts.



Wat vindt u belangrijk als u in contact bent met deze personen?

In het contact met mijn professionele contacten vind het het belangrijk om/dat....

Gebruik de voorbeelden om te helpen:

- ☐ **Begrip:** gehoord en gezien worden
- ☐ **Elkaar uitdagen**
- ☐ **Waardering geven en krijgen**
- ☐ **Intimiteit**
- ☐ **Gezelligheid:** plezier hebben
- ☐ **Controle:** eigen keuzes maken
- ☐ **Optimisme**
- ☐ **Stabiliteit:** weinig veranderingen
- ☐ **Veilig voelen**
- ☐ **Professionaliteit en expertise**
- ☐ **Open en eerlijk zijn**
- ☐ **Rekening houden met geloofsovertuiging**
- ☐ **Elkaar de ruimte geven**
- ☐ **Duidelijke afspraken maken**
- ☐ **Niet te veel tijd vragen van een ander**

Wat maakt u blij? 5

Waar wordt u momenteel vrolijk van? Waar geniet u van? Waar haalt u energie uit?

_____
_____
_____

Eigen keuzes maken

In hoeverre voelt u dat het leven u overkomt en in hoeverre maakt u zelf keuzes over uw zorg en toekomstige wensen?

Het leven overkomt mij volledig; ik maak zelf geen keuzes. ○—○—○—○—○ *Ik bepaal volledig zelf wat er gebeurt in mijn leven.*

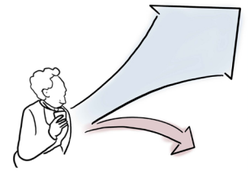
In hoeverre is geld belangrijk voor uw beslissingen over uw gezondheid, zowel lichamelijk als geestelijk?

Geld speelt niet mee in het maken van keuzes ○—○—○—○—○ *Geld speelt een grote rol in het maken van keuzes.*

Uw toekomst 6

Wat verwacht u van de komende jaren? Waar kijkt u naar uit en waar maakt u zich zorgen over?

Waar kijkt u naar uit, wat hoopt u nog te bereiken?



Wat vindt u spannend of waar kijkt u tegenop?

Wat verwacht u van Surplus? Wat denkt u nodig te hebben van hen?

Uw kladbord

Voor al uw notities en vragen die u heeft om te bespreken in het kennismakingsgesprek

Dit kladbord kunt u vrij gebruiken.

Is er bijvoorbeeld nog iets wat u van Surplus wilt weten?

10. T-Doos questioncards

And the tea label questions

DAGELIJKSE BEZIGHEDEN

Hoe ziet uw dag er vandaag uit? *Schrijf hier op wat u vandaag doet*

Ochtend

..... uur sta ik op uit bed

Middag

Avond

Nacht

DAGELIJKSE BEZIGHEDEN

Waar loopt u (soms) tegenaan? *Schrijf hier op wat moeilijker gaat*

Ochtend

Soms heb ik moeite met....

Middag

Avond

Nacht

CONTACTEN

Met welke specialisten heeft u regelmatig contact? *Bijv. huisarts, gemeente, audicien, fysiotherapeut.*

Bijv: Mr. Jansen, huisarts

z.o.z.

CONTACTEN

Wat vindt u belangrijk als u contact heeft met deze personen? *Bijv. elkaar uitdagen, geloofsovertuiging, veilig voelen, waardering, gezelligheid, intimiteit, geen tijd vragen van de ander.*

BLIK VOORUIT

Waar kijkt u naar uit in de komende jaren? Wat hoopt u te bereiken?

z.o.z.

BLIK VOORUIT

Wat vindt u spannend in de toekomst? Waar ziet u tegenop? Waar maakt u zich zorgen over?

DAGELIJKSE BEZIGHEDEN

Welke van deze dagelijkse dingen doet u nog zelf? *Kleur de rondjes in die voor u gelden*

- Koken
- Boodschappen
- Schoonmaken
- Naar toilet gaan
- Aankleden
- .....
- Wassen van kleding
- Douchen
- .....

z.o.z.

DAGELIJKSE BEZIGHEDEN

Hoe woont u nu? *Kleur de rondjes in die voor u gelden*

- Vrijstaande woning
- Appartement
- Tussenwoning
- Huis met trappen
- .....
- .....

CONTACTEN

Wie zitten er nu in uw sociale kring? *Bijv. vrienden, familie, buren.*

Bijv: Ans, vriendin

z.o.z.

CONTACTEN

Wat vindt u belangrijk als u contact heeft met een specialist? *Bijv. elkaar uitdagen, gelijkwaardigheid, geloofsovertuiging, veilig voelen, waardering, professionaliteit, expertise.*

BLIK VOORUIT

Wat verwacht u van Surplus?

z.o.z.

BLIK VOORUIT

Hoeveel bepaalt u zelf in uw leven (denk aan keuzes over uw zorg en toekomstige wensen)? *Kleur het rondje dat voor u past.*

Ik beslis niks zelf, het leven overkomt mij gewoon.

Ik beslis alles zelf in mijn leven.

DAGELIJKSE BEZIGHEDEN

Hoe verplaatst u zichzelf momenteel? *Kleur de rondjes in die voor u gelden*

- .....
- .....

z.o.z.

DAGELIJKSE BEZIGHEDEN

Wat gebruikt u voor communicatie en administratie? *Kleur de rondjes in die voor u gelden*

- Chatten met smartphone
- Administratie op papier
- Administratie digitaal
- Mailcontact
- .....
- Videobellen

PLEZIER

Wat maakt u blij, wat geeft u energie, waar wordt u vrolijk van?

z.o.z.

PLEZIER

Welke hobbies doet u graag? *Kleur de rondjes in die voor u gelden*

- Wandelen buiten
- Spelletjes
- Sporten
- Handarbeid
- Culturele uitjes
- Lezen
- .....
- .....
- .....

WELKOM!

surplus

NOTITIES