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Experiences and Needs of Nursing Staff Caring for Double Care Demanding Patients: A Qualitative Study

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Abstract

Nursing staff has a key role in the multidisciplinary care for patients with combined mental (psychiatric and/or psychogeriatric) and physical problems (DCD-patients). This study explores the experiences and needs of DCD-nursing staff in Dutch mental healthcare (MH) and nursing home (NH) settings, to identify factors to provide optimal care for DCD-patients. A qualitative approach was used, consisting of five semi-structured focus group interviews with DCD-staff (n=28) from MH- and NH-settings in the Netherlands. Five levels of factors were identified: (1) Patient-related factors (complexity of combined care needs, and complexity of behavioral problems); (2) Informal care-related factors (misapprehension of DCD-complexity, and involvement of volunteers); (3) Professional care-related factors (competences and attitudes, well-matched multidisciplinary team, and collaborative care between MH- and NH-settings); (4) Living and work environment-related factors (staff availability and continuity, and facility requirements); and (5) Organization-related factors (clear DCD-care policy, and provision of specific training and coaching). DCD-staff stressed the importance of team-efficacy, depending on commitment, mutual trust, and good communication- and collaboration skills; of experiencing a psychologically and physically safe work-environment; and of empowerment through the acknowledgment of the specificity of DCD-care and the teams' specific qualities regarding DCD-care. These findings can be used to optimize DCD-care.

Keywords: Focus groups; Multidisciplinary; Collaboration; Team climate; Team work; Long term care

Introduction

Many older people suffer from multiple morbidities, with combined mental (psychiatric and/or psychogeriatric) and physical problems [1,2]. This so-called double care demanding (DCD) patients require a combination of physical, psychogeriatric and psychiatric care [3,4], and usually end up in long-term care (LTC) facilities.

Different types of LTC are provided to older people with physical disabilities, advanced dementia or disabling psychiatric illnesses. In the Netherlands, tight networks of regional nursing homes (NHs) and integrated mental healthcare institutions (MHs) exist. Traditionally NHs provide LTC for either physically or cognitively disabled older patients, while MHs provide LTC for patients with chronic mental illness. Earlier studies showed that DCD-patients benefit from a multidisciplinary approach, including a collaborative approach of psychiatric, physical, and nursing interventions [5].

For economic reasons, the number of psychiatric hospital beds has decreased in many Western countries, including the Netherlands [6]. Since then, worldwide, a heterogeneous range of LTC-facilities has partly taken over the traditional asylum function for older adults with severe mental illness (SMI). Whether these facilities address the psychiatric care needs adequately has been questioned [7]. A study by the Dutch Trimbos Institute found that, according to NH-personnel, 8.4% of the Dutch NH-residents were DCD-patients who surpassed the capabilities for psychiatric treatment available in their own NH-department [8]. Qualified psychiatric nurses are still rarely employed within NHs, and specific psychiatric training for personnel is limited [9]. Despite the knowledge that patients with SMI have a high prevalence of physical disorders and are less competent in interpreting physical symptoms [10], it has been stated that MHs should focus greater attention on the physical needs of DCD-patients and should provide official guidelines to help identify and treat physical complications [11]. Based on these challenges encountered in providing appropriate care for DCD-patients, some Dutch NHs and MHs developed specialized care units to allow targeted allocation and care for this specific group of patients.

Results from explorative studies on these specialized DCD-units have shown that the group of DCD-patients is quite heterogeneous in both the MH- and the NH-setting [12,13]. They tend to be young, more often male, and to have low family support. All DCD-patients displayed a high number of neuropsychiatric symptoms, ADL-care dependency, and physical multimorbidity [12,13], although, expectedly, psychopathology was more prominent in the MH-DCD-group [12]. The high care dependency and the variation in neuropsychiatric patient characteristics present a challenge to the nursing-staff across both settings, as they must address somatic care needs, as well as psychiatric and psychogeriatric care needs. Research into the impact of caring for DCD-patients on the mental well-being of nursing staff showed that well-being and performance of nursing staff

might benefit from specializing care so that patients with similar care needs are placed together, and care is focused. Study results also showed that despite the overall finding of relatively high levels of self-efficacy and job satisfaction, MH-nursing staff seemed to be more at risk for burnout. Differences in patient characteristics or work experience of nursing staff across settings could not explain this finding [14].

As nursing staff have a key role in the care for DCD-patients, it is especially important to examine and describe their viewpoints in order be able to develop tailored interventions to provide optimal care for DCD-patients as well as a sustainable workforce with minimal costs of burnout. We, therefore, performed a qualitative study with the following research question: "What are the perceived needs and wishes of nursing staff caring for DCD-patients on specialized DCD-units"?

Materials and Methods

Study design

We conducted a qualitative focus group study. Focus groups are effective to gain in-depth insights from different perspectives and to capture the interaction between participants [15]. Because of the complexity of the subject, we purposefully worked with small sample size groups of four to eight participants [16]. We organized five focus group meetings from April 2017 to December 2017. Four groups consisted of nursing staff. A fifth focus group was performed to verify if the needs and wishes of the nursing staff were recognized and supported by the other multidisciplinary team members. Relevant aspects of this study are reported following the Consolidated Criteria for Reporting Qualitative Research (COREQ) [17].

Setting

The study was performed in Limburg, the most Southern province of the Netherlands. MH- and NH-organizations were approached to identify suitable wards for our definition of a specialized DCD-unit: "specialized units for patients with a combination of psychiatric, physical, and/or psychogeriatric care needs". The multidisciplinary team composition on these DCD-wards varied (see Table 1). Two focus group interviews with nursing-staff were organized in an NH, and three focus group interviews (two with nursing staff and one with a mixture of MH- and NH-multidisciplinary staff) were organized in an MH-setting, to realize triangulation of sites. The interviews were held in a quiet meeting room, conducted in Dutch and lasted approximately 90 min each.

Occupation of team member	Mental Health Institution	Nursing Home
Certified vocational nurse	+	++
Bachelor's degree nurse	++	+
Specialized nurse*	+	+
Social worker	+	+
Physiotherapist	+	+
Occupational therapist	+	+
Health care psychologist	+	+
Clinical psychologist	+	-
Geriatric psychiatrist	+	Consultation basis
Elderly care specialist	+	+
Geriatrician	+	Consultation basis
Note: Legend: + = present; ++ = highly present; * = Specialized in behavioural problems		

Table 1: Composition of multidisciplinary team in different settings.

Participants

The participants consisted of general nursing staff and other representatives of the multidisciplinary team (specialized nurses, nurse-managers, psychologists, physicians). A combination of purposeful and criterion sampling was used to achieve a range of diverse participants from different DCD-units with variation in experience and education [16]. Employees from DCD-units in MH- and NH- settings with a permanent contract were recruited. Potential participants were informed about the study in writing, with the possibility to ask questions. In total, 21 nursing staff members and 7 multidisciplinary team members agreed to participate. Sampling ended when data saturation was achieved [18]. In accordance with the methodological guidelines, data saturation occurred after four focus group sessions, with a total of 19 participants [15]. A fifth focus group session was organized to gain a multidisciplinary perspective into the subjects derived from the previous interviews.

Data collection

We used an interview guide with open questions during all focus groups. A question route was defined; starting with general issues and then moving towards more specific issues for more in-depth information (see Appendix 1).

To sensitize participants of the first four focus groups, we asked them to write a case with which they could illustrate successful or problematic DCD-care in advance. The participants of focus group five were asked to read a summary of data of the first four focus group interviews previously. This priming method is a derivative of the sensitizing phase of the context-mapping approach, in which participants are triggered and motivated to think about the subject prior to the actual session, thereby maximizing the efficiency of the interviews and capturing the most relevant topics [19]. At the start of the focus group meeting, we informed participants about the aim and method of the study and asked them to fill in a consent form. Then, all participants briefly introduced themselves. During the interviews, the focus was clearly on the experiences of the DCD-nursing staff in their daily work with DCD-patients. The interviewer encouraged participants to talk freely about what they considered important. A second researcher was present to facilitate the meeting and to report observations as field notes.

Data Analysis

All focus group interviews were audiotaped and transcribed verbatim. We used the qualitative data analysis Software Nvivo -11 [20] to organize and code the transcripts from the interviews. We analyzed both the transcripts and our field notes with an inductive content analysis approach, starting with the breaking down of transcripts into open codes, based on the content they display. Subsequently, we grouped the coded material into subcategories and broader categories,

and finally into a set of key themes based on shared concepts [16]. Two independent researchers (JC, DA) first coded the transcripts. Discrepancies in coding were discussed and, in case of permanent disagreement, a third researcher (MdV) was consulted. The research team decided on the final set of key themes and subcategories. To allow for scientific publication, we translated the quotes from Dutch to English.

Trustworthiness

We used purposive sampling to enhance the transferability of the results. We documented the recruitment process and interview schedule. The interviewers (JC, DA, and JS) were familiar with the patient group but did not work with the participants directly. We pursued the credibility of the research by investigator triangulation, which entails double coding all conducted interviews and field notes. After every interview, peer-debriefing sessions with the research group were performed to reflect on the research process, on the analysis and the interpretation of the data, and on data saturation. To increase accuracy, validity, and credibility, we performed a member check. We sent the main findings to all nursing staff participants, giving them the opportunity to comment and verify these findings [21].

Results

Participants

A total of 28 nursing staff and multidisciplinary team members agreed to participate in the study. Two nursing staff members canceled due to sickness just before the planned interview, yielding a total of 19 nursing staff members and 7 other multidisciplinary team members. The sample consisted of 13 MH-participants and 13 NH-participants. The mean age of the participants was 44 years and mean work experience was 15.2 years. All participants were involved in the member check. Table 2 shows the characteristics of these participants in detail.

Participant	Professional background	Sex (F/M)	Age (years)	Work Experience (years)	Age (M, years)	Work Experience (M, years)
M.1.1	Bachelor nurse	M	22	2		
M.1.2	Master nurse	F	44	7		
M.1.3	Bachelor nurse, geriatrics	F	48	19		
M.1.4	Bachelor nurse	F	32	8		
M.1 (total)					37	9
M.2.1	Senior bachelor nurse	F	50	10		
M.2.2	Bachelor nurse	F	48	7		
M.2.3	Master nurse; unit manager	F	40	16		
M.2.4	Master nurse; mental health expert	F	39	15		
M.2.5	Master nurse; unit manager	M	40	21		
M.2.6	Bachelor nurse; unit manager	M	34	3		
M.2 (total)					42	12
N.1.1	Certified vocational nurse	F	54	15		
N.1.2	Certified vocational nurse	F	26	2		
N.1.3	Certified vocational nurse	F	62	41		
N.1.4	Bachelor nurse (behavioural expert)**	M	48	18		
N.1 (total)					48	19
N.2.1	Bachelor nurse	F	25	1		
N.2.2	Bachelor nurse*	F	62	10		
N.2.3	Certified vocational nurse*	F	60	30		
N.2.4	Bachelor nurse; unit coordinator	M	42	22		
N.2.5	Master nurse; unit coordinator	F	54	30		
N.2 (total)					49	19

MN.1	Team manager (NH)	F	50	30		
MN.2	Nursing specialist Mental Health (MH)	F	42	14		
MN.3	Health Care Psychologist (MH)	F	39	16		
MN.4	Social worker (NH)	F	63	36		
MN.5	Elderly care specialist (MH)	F	44	10		
MN.6	Elderly care specialist (NH)	M	35	4		
MN.7	Nursing specialist Mental Health (MH)	F	33	12		
MN (total)					44	17

Note: M.1: Focus group 1 with MH general nurses in direct DCD-care; M.2: Focus group 3 with MH nurses with managerial or coordinating tasks, next to DCD-care; N.1: Focus group 2 with NH general nurses in direct DCD-care; N.2: Focus group 4 with NH nurses with managerial or coordinating tasks, next to DCD- care; MN: Focus group 5 with mixed MH/NH multidisciplinary team members; NH: Nursing home; MH: Mental Health Care Institution; *: with first responsibility in the care for a number of DCD-patients; **: followed specific courses and has an advisory role in complex behaviour.

Table 2: Characteristics of included participants.

Focus group interviews

Inductive content analysis of all focus group interviews resulted in a set of five key-levels of factors regarding the needs and wishes experienced by DCD-nursing staff: (1) patient-related level, (2) informal care-related level, (3) professional-related level, (4) living and work environment-related level, and (5) organization of care-related level. The coherence of these five key-levels, within the DCD-setting, is displayed in Figure 1. Several categories were identified within the key-levels and further illustrated by quotes. Each quotation is assigned the code of its respondent, corresponding with the list of participants as presented in Table 2.

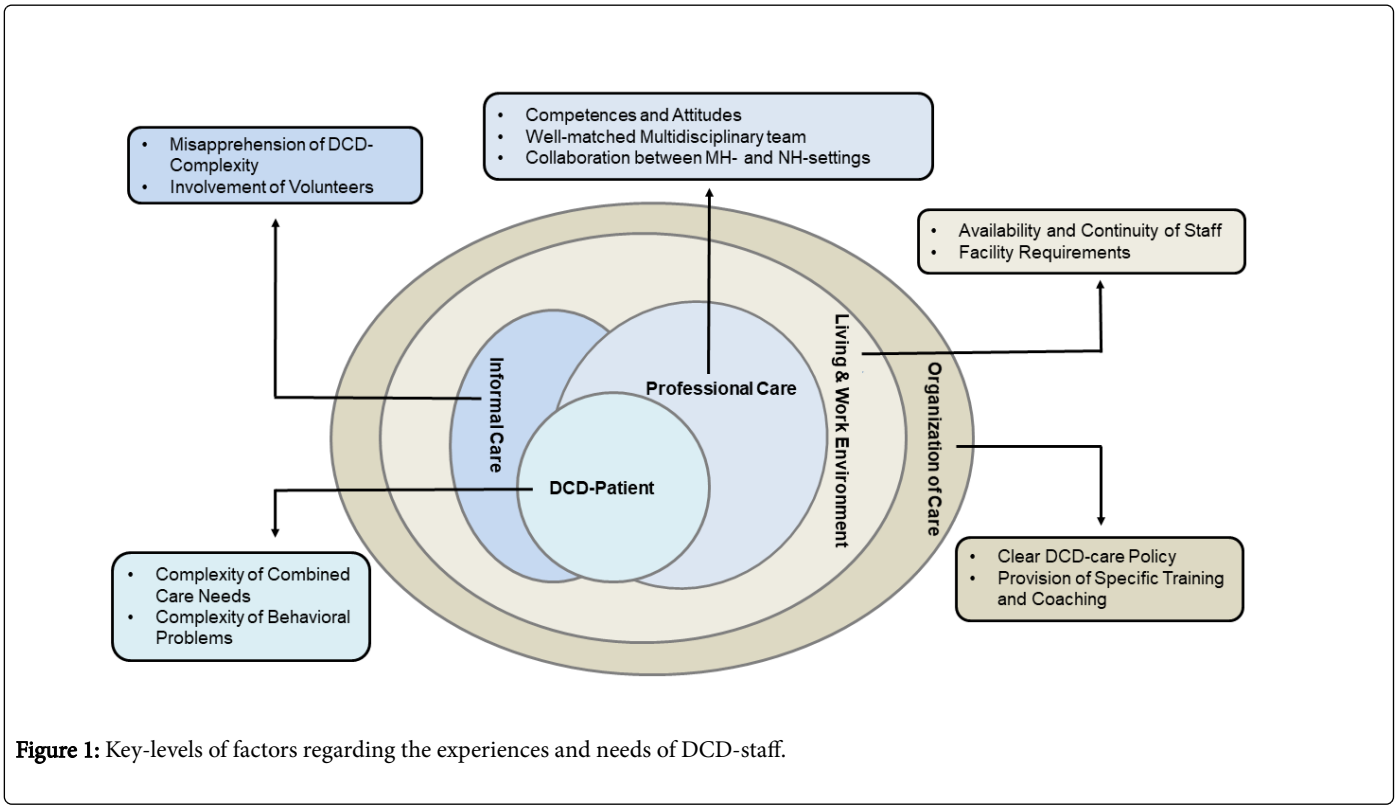

Figure 1: Key-levels of factors regarding the experiences and needs of DCD-staff.

Patient-related factors

The complexity of combined care needs: In both settings, most participants have consciously chosen to work with DCD- patients. For all participants, the complexity of combined psychiatric, physical, and/or psychogeriatric care needs makes DCD-care unique, inspiring, interesting, and rewarding. It provides an opportunity to be creative and think outside the boxes.

"There are often puzzling problems that can't be easily solved. It is usually through working very intensively with patients and their family that you get to know their background and history so that you eventually understand what is going on." (N1.4)

The complexity of combined care needs and the heterogeneity of patients, however, also provide challenges for the nursing staff. In both settings, patients' increasing physical care demands were stressed. Especially patients with personality disorders were perceived as highly demanding because they can be hurtful and disqualifying. MH-nursing staff expressed that assessing the severity and seriousness of physical complaints is often complicated by the presence of psychiatric symptoms.

"This patient had a narcissistic personality disorder and did not accept any care. We could not connect with him in any way." (N2.2)

"I find it very difficult whether to take the patient seriously and pay attention to his pain. To what extent is it dismissed as something psychiatric? Finding that balance is very complicated. I do not want to nourish the patient in something that does not exist, but I do not want to deprive the patient either." (M1.2)

The complexity of behavioral problems: Unpredictable and unintelligible behavior, especially agitation and both verbal and physical aggression towards nursing staff and fellow DCD-patients are experienced as highly demanding, and stressful. These behaviors have a negative impact on nursing-staffs' well-being and a feeling of safety. The growing amount of younger and physically strong patients increases the impact of physical aggression even more. The shifting boundaries regarding aggression, thereby almost allowing and accepting aggression as part of the job were also stressed.

"Both the frequency and intensity of aggression incidents increase. This is worrying and also makes staff more anxious about running evening shifts or night shifts". (M2.3)

"The risk exists we will push our boundaries, over and over again, because we realize that this behavior is not intentional, but due to the illness". (N2.2)

Informal care-related factors

Misapprehension of DCD-complexity: Communication and collaboration with family and friends are often hampered by their lack of understanding of the complexity of DCD-patients' problems and the required interventions. Verbal and physical aggression of family members towards both staff and the DCD-patients was described as very challenging in both settings.

"We do have problems with non-cooperative family members, who do not understand the needs of the patient, may act aggressively and refuse to adhere to treatment plans." (M1.1)

The importance of the timely involvement, informing, and educating of family members and representatives was stressed. The provision of background information by the family is experienced as very worthwhile. Informative consultations with a physician or a psychologist are found to be necessary to inform family and representatives of treatment possibilities so that expectations are realistic. The availability of open access informative courses regarding specific psychiatric diseases and other topics are experienced as supportive in the MH-setting. "We should certainly explain the symptoms and course of certain syndromes. I think adequately informing family members might ease things." (M1.3)

Involvement of volunteers

If the family is not involved, as is often the case in especially the MH-DCD-setting, volunteers can be deployed to take over 'family tasks', such as guidance to a dentist appointment or social events outside the DCD-unit. Although the nursing staff generally welcome these volunteers, several problems were mentioned. Nursing staff stressed that 1) Volunteers should never be a replacement for certified nurses; 2) Volunteers must never act without consultation of nursing staff because of their difficulties interpreting complex psychiatric behavior; and 3) Clear rules regarding confidentiality of patient data and task allocation are needed.

"I notice a tendency of shifting tasks from qualified nurses to volunteers. Volunteers in different places of the organization, including the nursing-unit and the restaurant are getting too much responsibility. They are dealing with a very difficult population." (M3.6)

Professional care-related factors

Competencies and attitudes: Affinity with and commitment to DCD-patients and DCD-care, as well as having a learning attitude, being a team-player and a good communicator were mentioned as needed conditions for all team members in all focus groups. The complexity of the target group requires specific competencies. One has to be open-minded, able to negotiate, apt in crisis management, reflective, creative, and patient. Nursing staff in both settings felt confident and competent in working with DCD-patients, because of their sufficient knowledge and skills in both the psychiatric and physical care domains. MH-nursing staff perceived being able to provide structure and boundaries to be essential, while in the NH-setting a focus on providing affectionate care was mentioned. From a multidisciplinary perspective, the importance of mutual trust and openness and of both dedication to DCD-care and creativity in finding solutions to complex and unusual situations was also underpinned.

"Mutual trust is essential so that you feel free to comment and ask questions, without feeling guilty or stupid about not knowing something" (MN.4)

Well matched multidisciplinary team

Every focus group underlined the importance of good teamwork. Participants discussed the relevance of both nursing staff collaboration and multidisciplinary collaboration. A working atmosphere with mutual trust, appreciation, and respect was perceived as facilitating, and a strong hierarchical environment as hindering. The importance of honest, respectful and open communication towards both colleagues, patients, and relatives were emphasized. This entails listening, asking the right questions, expressing expectations, and taking each other seriously. It is also important to know each other's expertise. Discussing and evaluating difficult situations and getting support from colleagues are important factors in creating a feeling of safety and unconditional trust. Participants emphasized that DCD-care requires a well-matched team, where all team members are on the same page and stick to the treatment plan.

"If you know you can trust your team, then you are not afraid". (N2.5)

"You must be able to apply individual treatment plans; otherwise, you do not belong in DCD-care. Patients will play you off against colleagues and will treat you disrespectfully if you don't keep up with the agreements made." (N1.3)

Participants highlighted the necessity of a multidisciplinary approach in working with DCD-patients. Addressing complex issues from different perspectives helps to find solutions. All team members should be easily accessible, open to feedback, and committed to DCD-care. Incidents in patient care should be discussed in a low-threshold manner. The employment of specialized behavioral expert nurses is facilitating, because of their expertise, supervising, and mediating role. The unit-leader has a valued connecting role within the team, by ensuring that any problem is discussed, reported (for instance aggression incidents), and evaluated.

“Both the physician and the psychologist are always aware of the teams’ problems. This is facilitating and supportive.” (N2.2)

Collaboration between MH- and NH-settings

The collaboration was essential in the referral of NH-DCD-patients for either psychiatric diagnostic examination or therapy and vice versa of referral of MH-DCD-patients, who no longer need intensive psychiatric care. Knowing and accepting each setting’s limits of professional competence, low thresh-hold professional contacts between settings and the provision of accurate information about the care needs of a DCD-patient were perceived as facilitating in this referral process.

"The NH-psychologist simply called to ask if we (MH-setting) were familiar with the patients’ behavior and if we could provide specific behavioral advice?" (MN 7).

The severity of psychiatric symptoms (unpredictable behavior especially), the existence of waiting lists, unfamiliarity with judicial authorization, and the prevailing stigma about psychiatric patients were mentioned as the main obstacles in transferring DCD-patients from an MH- to an NH-DCD-unit. Participants also indicated that cultural differences or domain thinking between settings could obstruct their collaboration.

"No nursing home wants to have schizophrenics with many delusions." (M2.3)

"I think they (MH-setting) would only be able to handle her if she was tranquilized and kept isolated”. (N1.3)

Living- and work environment-related factors

Staff availability and continuity: All participants stressed that DCD-patients are very vulnerable and need a permanent team with as few changes as possible to create a safe living environment. They often need individual guidance to be able to perform appropriate daytime activities. The availability of sufficient nursing staff was perceived as a bottleneck in both the evening, weekend, and night shifts. MH-staff especially expressed a feeling of frustration, because they cannot apply their professional skills to de-escalate aggressive DCD-patients properly due to staff shortages. Across settings, a feeling of demotivation was described, because ever more tasks, such as administration and cleaning, are requested at the expense of their actual nursing work. From a multidisciplinary perspective, the importance of availability and continuity of nursing staff to facilitate good teamwork was also stressed.

“It feels unsafe when there is no supervision in the living room. You never know what happens. Then I worry about the safety of the residents.” (N1.4)

“Nurses often feel understaffed. This increases their workload in dealing with these complex patients. When nurses are overburdened and get annoyed, this subsequently has a negative impact on collaboration, communication, and patient care." (MN.7)

Facility requirements

Oversight and supervision must be guaranteed at all times to create safety for both patients and staff. DCD-units should have sufficient safe indoor (multiple rooms) and outdoor space so that stimuli can be varied, and patients are not irritated by being too close together. There must be private and strippable bedrooms with private bathrooms, where strict room treatment can be applied if needed. The NH-nursing staff recommended the use of doors with the possibility of opening the upper part separately, to enable contact with staff or fellow DCD-patients within a secure environment. Although camera surveillance is helpful, this should never replace face-to-face contact with a DCD-patient. MH-staff stressed that the use of supportive electronic devices could even trigger aggression, as psychotic and distrustful patients for instance simply do not understand “that soothing voice coming from the wall”.

"If one patient’ behavior changes, the other patients will join. They reinforce each other's behavior ". (MN 5)

Organization-related factors

Clear DCD-care policy: Managers should be familiar with the target group and acknowledge their complexity and their specific care requirements. All participants wanted to feel valued for their expertise in DCD-care and liked to be more involved in DCD-policy within their organization. Clear admission criteria are required to ensure patient admission to the most appropriate DCD-setting and to prevent admission of non-DCD-patients to a specialized DCD-unit. These patients will not receive the most appropriate care, while the therapeutic climate of the actual DCD-patients becomes disrupted.

"Someone, who is introduced beforehand as being very calm, but actually screams 24 hours a day.… If you can no longer rely on admission information, ….. what can you do? "(MN7)

Family or representatives should be better informed at admittance to the unit, that a transfer or relocation will be arranged if specialized DCD-care is no longer needed. The NH-staff felt more empowered and supported by their management, while the MH-staff experienced minimal influence on the admittance of appropriate DCD-patients and felt less acknowledged by the management.

'If we analyze it as a team and have a well-motivated story, the management will not hesitate to temporarily facilitate extra finances or resources." (MN.6)

'I think we have limited influence on who gets admitted to our unit. Patients are on a waiting list, and they will just arrive." (M.2.2)

The MH-multidisciplinary staff mentioned the sometimes-frustrating search for care-transition possibilities of a small group of DCD-patients with therapy-resistant behavioral problems, without the prospect of substantial recovery. They thought that it could improve patients’ quality of life just to accept their life-long need for MH-DCD-care.

Provision of specific training and coaching

The currently provided training in both the psychiatric and physical care domains was experienced as rather basic. Nursing staff wanted to be challenged with more-in-depth training in geriatrics, pharmacotherapy, and challenging behavior. A wish for more specific training in counseling strategies and in recognizing the influence of their own personal characteristics when interacting with DCD-patients or family members was also expressed. The nursing staff especially indicated a need for team coaching. They need time to reflect, to get to know and trust each other, to recognize personal pitfalls, and to learn from each other and identify solutions together. Sharing difficult situations with fellow team members prevents them from becoming emotionally exhausted.

“Due to cutbacks, team coaching programs no longer exist. I think it is essential to talk about self-reflection, about how we look at the patient population, and how patients perceive us. Nowadays, we are only busy to get through the day, to get through the week, to keep the beds occupied." (M2.6)

Participants stressed that in general too little attention was paid to psychiatry within the educational nursing schools. Special interest was requested for the supervision of new colleagues and student-nurses. Enough time and “manpower” are needed for this so-called training-on-the-job, to share DCD-experience, knowledge, and skills as best as possible and to create a sustainable workforce.

"We still receive trainees who know nothing about psychiatry. It is almost as if you would put a trainee in the intensive care unit immediately. "(M2.4)

Discussion

The aim of this qualitative focus group study was to identify the experiences, needs, and wishes of nursing staff and other multidisciplinary team members in the daily care for DCD-patients. Results showed that experiences of DCD nursing staff could be described on five levels: (1) Patient-related factors (complexity of combined care needs, and complexity of behavioral problems); (2) Informal care-related factors (misapprehension of DCD-complexity and involvement of volunteers); (3) Professional care-related factors (competencies and attitudes, well-matched multidisciplinary team, and collaborative care between settings); (4) Living- and work environment-related factors (staff availability and continuity, and facility requirements); and (5) Organization-related factors (clear DCD-policy and provision of specific training and coaching).

The complexity of the target group shows both advantages and disadvantages to nursing staff, and several preconditions and unmet needs were expressed. We will discuss these findings in more detail.

As a starting point of successful multidisciplinary DCD-care, “motivation for”, “affinity with”, and “commitment to” the target group were mentioned. In different settings, this so-called work engagement counterbalances work-related stress reactions and has a positive influence on the well-being of nursing staff, despite their high workload [22]. Also, the results show the importance of knowing each other and of building mutual trust and respect among all team members for creating a psychologically safe environment that enables staff to collaborate effectively in DCD-care. This is in line with the findings of van Dongen et al., who found that mutual trust and respect are important preconditions for effective inter-professional collaboration [23].

In line with our previous findings, DCD-nursing staff across settings felt motivated and competent in providing care to DCD-patients, despite the complexity of their combined mental and physical care needs [14]. Aggressive behavior, however, from both patients and family, was perceived as highly demanding and stressful to all DCD-staff. Our finding that nurses sometimes almost try to "sympathize" with the aggression expressed by the patient or family is rather alarming. Aggression incidents are known to have a severe emotional and psychological impact, which may negatively affect nurse's professional performance [24]. We know that communication about safety between hospital leaders and unit-managers regarding aggression incidents might improve patient safety and registered nurses' (RNs) trust in hospital management [25]. A more recent study, however, demonstrated that addressing patient and visitor aggression remains challenging due to 1) The main use of formal incident reports for statistical purposes, instead of also serving as a tool to enhance communication between nursing staff and management; and 2) A lack of awareness in the organization and scant financial resources [26]. Our study results actually stress the importance of the implementation of strategies to prevent DCD-patient and family aggression, the need of adequate training to cope with this aggression, and the need to change nurses' perceptions and attitudes that violence is acceptable and "comes with the job" [27].

DCD-patients are vulnerable and need both individual guidance and a permanent team to create continuity of care. This underlines the findings of Orchard et al., who describe continuity of care as a key element of interprofessional collaborative practice [28]. Sufficient availability and continuity of nursing staff and the experienced facilitating role of expert nurses were expressed across DCD-settings. Up until now, however, no consistent evidence exists between the amount of nursing staff, the educational level of team members, and the quality of care [29]. There is some evidence that the employment of registered nurses (RNs) reduces aggressive behavior, but no consistent relationship was found between the presence of baccalaureate-educated RNs and quality of care [30,31]. Further research to establish the most appropriate skills-mix, therefore, seems necessary.

The present study indicated that the quality of DCD-care is to a great extent influenced by team- efficacy and team support. Higher teamwork, supportive leadership, and colleagues are known important factors related to a better quality of care [32].

Participants emphasized the need for several communicative and collaborative competencies to be able to offer effective multidisciplinary and tailored care to DCD-patients. This is in line with the findings of Backhaus et al. that better communication, coordination, and a higher rating for multidisciplinary collaboration were significantly associated with a higher grade for the overall quality of care in psychogeriatric wards [33]. It also affirms the finding that nurses with effective communication and negotiation skills are indispensable in achieving an effective dialogue with DCD-patients to optimize their individual care plans [34].

Our participants stressed the importance of individual- and team-coaching and training in counseling strategies to recognize and reflect on the influence of their own personal characteristics when interacting with DCD-patients, families, volunteers, and other team members. Team training can improve interprofessional collaboration and trust and enhance team performance [35,36]. Training on the job was perceived as especially necessary for trainees and newly graduated nurses, who might be inadequately equipped with the needed skills to work with DCD-patients. This is in line with the findings of previous

studies stating that, according to clinically based colleagues; the "newly qualified" are not work-ready and benefit from supportive preceptorship in adopting necessary clinical and managerial skills [37,38].

Supporting employees by providing access to training, sufficient resources, and support from supervisors is called structural empowerment. Compared to the NH-nursing staff, the MH-nursing staff felt less empowered; not feeling involved in decision-making processes and not feeling the acknowledgment of the specificity of DCD-care were perceived barriers. Van Bogaert et al. demonstrated positive associations between characteristics of empowerment (e.g., balanced workload, and decision latitude) and low feelings of burnout, job satisfaction, and low turnover intentions in (psychiatric) hospital nurses [39]. Supportive managers and a supportive nursing team were crucial for structural empowerment, while lack of time and perceived work demands were viewed as barriers [40].

A need for adequate DCD network care or an adequate chain supply of DCD-services was stressed. Management should provide clear admittance criteria. Multidisciplinary teams from both the MH- and the NH-setting must work together to provide continuity in DCD-care. Clear agreements are needed for consultation of MH-professionals to an NH-DCD unit and for referral of NH-DCD patients to psychiatric treatment that is not possible in the nursing home. The transition of DCD-care from an MH-setting to the NH-setting, and vice versa, involves exchanging complete patient information, as well as showing mutual trust and respect for each other's expertise. This is congruent with earlier studies, concluding that liaison psychiatry or short admittance of NH-patients to a psychiatric hospital could be helpful [5,41].

Strengths and Limitations

To our knowledge, this is the first focus group study to identify the nursing staff's experiences and needs in the daily care for DCD-care in multiple settings, also focusing on a multidisciplinary perspective. Another strength of our study is the mixture of participants involved in the various focus groups, thereby providing an in-depth perspective on the needs of DCD-nursing staff. All participants expressed personal views, and by using a moderator who was not directly working with the interviewed professionals, we limited bias. Unfortunately, not all multidisciplinary team members were able to join, and therefore the present study does not include the perspective of a psychiatrist, a physiotherapist, or an occupational therapist. Although we recognize the importance of the perspectives of these multidisciplinary members, during our study, data saturation occurred after four focus group sessions and the fifth session did not result in new themes or explanations but confirmed and acknowledged the results generated thus far. Finally, though our sample is likely to be representative of Dutch DCD-nursing staff in NH- and MH-settings, the number of DCD-units included is modest, and the representativeness for other DCD-settings and other countries remains unknown.

Conclusion and Recommendations

The complexity of combined care needs of DCD-patients is challenging and demanding. Pressure is clearly experienced on many levels. All participating staff members stressed the importance of the provision of a psychological and physical safe work-environment. Nurses must be able to rely on each other, on the multidisciplinary team, and on the support of their management. They need the security of a well-matched team with continuity of care, of coaching trajectories, and training of specific skills on both the psychiatric and somatic care domains. Interventions that focus especially on the strengthening of team efficacy, collaboration and communication skills, and the mutual understanding between management and DCD-staff seem to be desirable.

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Ethical considerations

The Medical Ethics Committee of the Maastricht University Medical Centre approved this study (METC 17-4-062).

Conflicts of Interest

There are no conflicts of interest for the present study. The authors alone are responsible for the writing and content of this article.

Appendix 1. Semi-structured interview guide

Introduction to focus group session

a) Introduction of the interviewer and observer

b) Consent for audio recording

c) Short introduction on the background and aim of the focus group: we want to collect qualitative data from nursing staff concerning their needs, wishes and perceived problems in caring for DCD-patients on specialized DCD-units

d) Duration and procedure of focus group session

e) Point out that all information is confidential and relevant

Round of introduction

Introduction of the participants: professional background, work-experience and reason to work with DCD-patients.

Questions regarding the DCD-patient:

1. What are the challenges in working with DCD-patients?

2. Can you describe specific complex patient characteristics?

a. Which patient characteristics are enervating or rather exhausting?

3. What do you experience as helping in dealing with this specific group of patients?

4. How do you handle challenging or difficult behavior?

5. Are there patients where you feel you fall short in care options?

a. Can you illustrate this with a case?

Questions regarding providing DCD-care:

1. Can you describe your experiences in working in DCD-care?

a. What is going well, what are you proud of, what are the challenges and where do you see opportunities for improvement?

b. Can you illustrate this with a case?

2. What are your needs to provide optimal DCD-care? What is the most desirable situation?

a. For instance: Do you need specific training to work with DCD-patients, or do you need specific tools or competences to care for DCD-patients?

3. Are there any regulations that you are supported by or that are bothering you in delivering DCD-care?

Summary of the focus group session

Provide a summary of the mentioned subjects, and inform if there is any relevant information, that has not been discussed, yet.

Member check

After completion of all focus group sessions, we will present a summary of the discussed topics. We will ask you to check if you can relate to this overview and if there are any topics missing.

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