Who cares? An ethnographic research on the workforce integration of first-generation immigrants in geriatric care in the Netherlands and Germany

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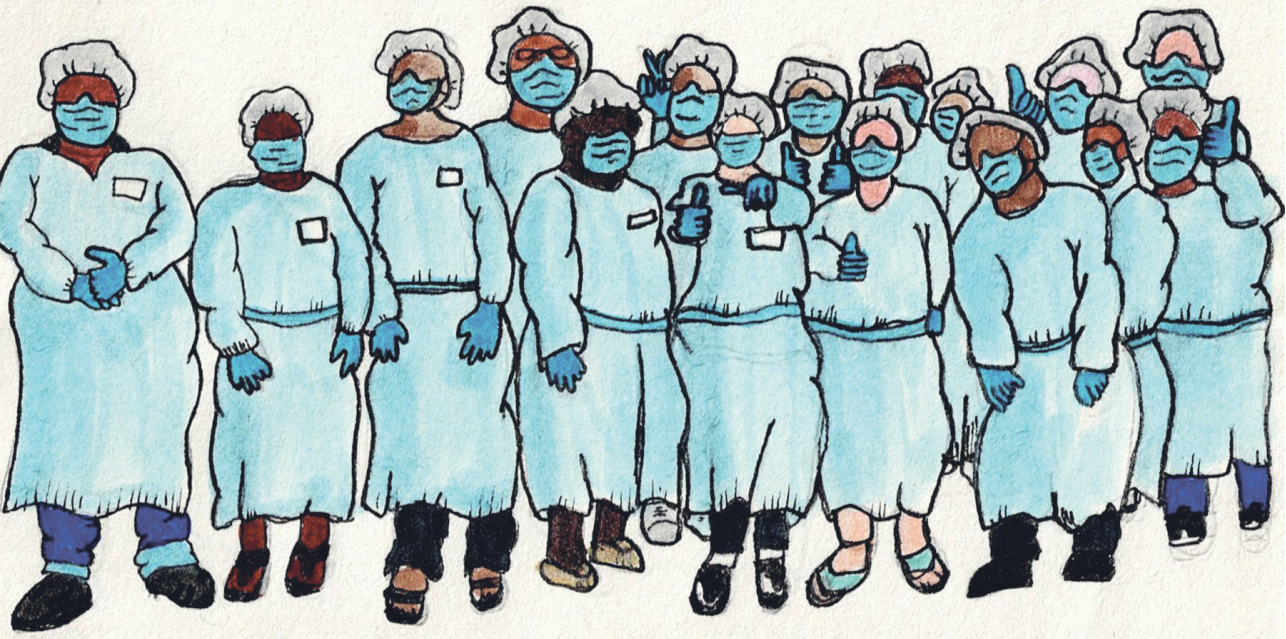

Chapter 5

WHO CARES?

An ethnographic study on the enactment of geriatric care by first-generation immigrants and established caregivers in a German residential home

"We need to hurry up"

This chapter is singled authored and a slightly different version is currently under review in an international peer reviewed journal as: Ham, A. *Who Cares? An ethnographic study on the enactment of geriatric care by first-generation immigrants and established caregivers in a German residential home*.

An ethnographic study on the enactment of geriatric care by first-generation immigrants and established caregivers in a German residential home

ABSTRACT

Introduction: A German residential home attempted to get recently arrived refugees interested in working in the residential home. This ethnographic study examines how established caregivers and these first-generation immigrants interact to enact quality care for people with dementia in a German residential home. **Method:** Ethnography, including 200 hours of participant observations, 24 in-depth interviews, 2 focus-group interviews with 6 first-generation immigrants and 6 established staff members. **Results:** The established caregivers and first-generation immigrants are able and willing to tinker in situations in which different values are at stake. However, when the workload becomes too heavy, staff from both groups feel powerless, indifferent and demotivated. **Discussion:** Institutional constraints have a negative impact on the interaction between established caregivers and first-generation immigrants. In such situations, we recommend all staff need an appreciative supervisor who supports both newcomers and established workers in coping with the daily stressors in practice.

Keywords: Germany, long-term care, residents with dementia, tinkering.

INTRODUCTION

In 2015, during the so-called "refugee crisis" that challenged many European countries, almost 500,000 asylum applications were submitted in Germany. Among the applicants were people who had obtained a nursing degree in their country of origin and people who were interested in starting a nursing career in Germany. Those first-generation immigrants with a refugee background were encouraged by the government to participate in the German workforce, especially in fields with a labour shortage, such as geriatric care sector (Duell and Vetter, 2020). Although nursing practices around the world have a lot in common, what counts as good nursing care differs from society to society. Nursing care is socially, culturally and politically shaped and influenced by organizational standards, rules and regulations. The enactment of care, i.e., the ongoing daily practice of caregivers (Benner, 2019), is connected to their education and previous (nursing) experiences. Employment is considered a successful strategy for integration of refugees in the new country (Hussein et al., 2011). However, when they start working in the new environment, they are faced with structural barriers. Some scholars argue that caregivers who were trained in non-European countries lack certain skills. Before they actually start working, they therefore, but need to follow re-training programs and obtain certain qualifications to meet the standards of the host country (Muller, et al, 2017). Some scientists argue that cultural differences, like variations in cultural values and communication styles, combined with poor language skills are barriers for first-generation immigrants to understand what is needed in the new healthcare environment (Moyce, et al, 2016; Xiao, et al, 2014). Other research in the care sector points out that many newcomers from non-western countries are faced with racism and discrimination by both colleagues and clients (Kingma, 2018; Ulusoy and Schablon, 2020; Zhou, 2014). Clients resist their care or colleagues do not want to work with them. To prevent such difficulties, other scholars argue that it is necessary to improve the cultural competency for all staff (Maltby, et al, 2016). The shortage of skilled caregivers is a major problem in many countries (Horn, et al, 2021). Germany is one of the most ageing populations in Europe and especially German residential homes experience a severe labour shortage. This shortage causes a heavy workload for the established caregivers, which leads to a high level of absenteeism. This creates even more work pressure for the remaining health care workers in the ward. To address these issues, many German residential homes have recruited staff from East-European countries, such as Poland, Slovakia,

Bulgaria and Russia (Menebröcker, 2021). In addition, they have been lowering their qualification requirements for care professionals (Horn, et al, 2021). These initiatives however could still not make up for the labour shortage in German residential homes, who now have turned to refugees and asylum seekers as a potential group for recruiting care workers (Hussein, et al., 2011). Because nursing scholars agree that good team collaboration improves the quality of care (Benner, 2019; Eika, et al, 2015), that interactions between established care providers and newcomers further workforce integration and improve the quality of care (Schilgen, et al, 2019). Some health care institutions who recruit international staff, offer their established staff cultural awareness and sensitivity trainings.

Each care home has developed a particular system of standards, rules and protocols, aimed at improving the quality of care of its residents and protect them from unacceptable, unnecessary interventions (Pols, 2013). Every institution thus subscribes to a set of interlinked values or goods (Mol, et al, 2010; Moser, 2008). Care plans, nursing goals, and protocols of evaluation are important professional instruments to operationalize and measure the quality of care (Struhkamp, 2004). However, a process such as goal setting is never a straightforward undertaking. In the setting of a dementia residence, clients are often unable to set goals for themselves, so clients need support from the staff (Moser, 2008; Struhkamp, 2004). Additionally, though goal setting in nursing care plans might be a good idea in theory, in everyday practice it does not necessarily lead to good care (Struhkamp, 2004). When a large group of refugees entered Germany in 2015, the management of a residential home in a small German town saw opportunities to interest some of them in working in geriatric care. They considered this as a win-win situation. On the one hand the residential home could offer newcomers a nursing orientation trajectory. On the other hand, these newcomers could lighten the heavy workload for the established workers. This paper focuses on the everyday interactions between the established caregivers and newcomers, once the latter started working on the wards of this residential home. The research question is: How do first-generation immigrants with a refugee background and established caregivers tinker in order to enact good care for residents with dementia in a German residential home? This study aims to illuminate how established caregivers and immigrant newcomers work together to enact care for older people with dementia.

GOOD CARE AND TINKERING IN GERIATRIC CARE: SITUATIONAL ACTING

The theoretical framework of this study consisted of Pierre Bourdieu's concept of 'habitus' and 'feel for the game', and the concept of 'tinkering' as introduced by the Dutch philosopher Annemarie Mol. According to Bourdieu (1990) people develop a certain habitus in the course of their lives, i.e., a set of ingrained habits, skills and dispositions created by their environment, or social 'field', in which they accumulate cultural, symbolic and social capital through interaction with others (Bourdieu, 1990; Mendoza, et al, 2012). The sector of geriatric health care can be perceived as such a field. People who work in similar circumstances and conditions, like care workers in a residential home, are more likely to share certain habits, skills and dispositions. Constantly negotiating with others within this field gives people a 'feel for the game', i.e., by working in a residential home for older people, over time, care workers acquire practical knowledge and a certain sense of how to behave in a given situation (Bourdieu, 1990; Mendoza, et al, 2012). The daily routine system of the residential home shapes the habitus of the care workers. But conversely, these workers also shape the habitus and daily routines in the home. In other words: the field of geriatric health care is not a fixed whole, but consists of a continuous dialectical process of the externalization and internalization of habits, skills and dispositions. This habitus of the established caregivers and immigrant newcomers i.e., the way in which they develop and transfer their 'feel for the game' of geriatric care, is central to this current study. To further operationalize this focus on the habitus of established caregivers and immigrant newcomers, we make use of the insights from Mol et al (2010), who claim that interactions between caregivers are crucial to the enactment of good care (Mol, et al, 2010). Mol argue that good care performance is often the outcome of tinkering, where tinkering is defined as activities through which caregivers adapt, attune, and calibrate their work toward the goods or values that matter most in that particular time and context (Mol, et al, 2010). Good care takes shape in close relationships and whether a certain practice counts as good care cannot be determined separately from those relationships (Moser, 2008; Struhkamp, 2004). The enactment of care is based on the values of care that care workers underline, on their assessment of what matters most in that particular situation. Care is a normative activity based on situational acting (Mol, et al, 2010; Moser, 2008; Pols, 2013). In this study therefore, good care is supposed to be the outcome of the tinkering of established caregivers and first-generation

immigrants between different values of care that in certain situations may either clash, coincide or interfere with each other. Caregivers may enact different forms of good care, and a single health worker may engage with different values of good care in different situations (Pols, 2013). Moreover, different values are relevant to different situations. In daily practice, conflicting values can cause friction, but they can also be observed simultaneously. This raises the question of how to evaluate care for older residents in practices of established caregivers and newcomers. How do caregivers tinker between conflicting goods, such as physical health or social well-being, autonomy or hygiene, and privacy or safety?

METHOD

Design

This study used an ethnographic approach with a focus on the method of shadowing (McDonald, 2005). This ethnographic method was chosen to yield *thick descriptions* (Hammersley and Atkinson, 2019) in order to better grasp the daily interactions between established caregivers and newcomers as well as to understand how they tinker between different values of care in the context of the residential home.

Data collection

This study is part of a larger ethnographic PhD research project (Ham, 2020; 2021a; 2021b). The first part of this project focused on the workforce integration of first-generation immigrants with a refugee background in a Dutch residential home in 2016 and 2017. The current article discusses findings from the second part of this project, for which data was gathered in 2018 in a German residential home for older people with dementia. To ensure validity, data was collected via triangulation (participant observation/shadowing, interviews, and focus group discussions) (Hammersley and Atkinson, 2019). This collection was carried out by the author, a Dutch anthropologist with a nursing background, who closely followed a number of newcomers during the period of their three months orientation project in the German residential home.

Participant observation was conducted between July to September 2018 for two to three days per week during classes, meetings, and internship hours (200 h). Seventeen recently arrived refugees were observed during the two months

training program. Three of them were observed afterwards, during their internship in the ward. The researcher participated in the training program and in the caring activities in the wards, made fieldnotes of her observations and gathered information through informal conversations.

24 in-depth interviews took place with six newcomers, with seven established caregivers (vocationally trained nurses and nurse assistants), six managers, and five teachers. These interviews focused on 1) differences and similarities between the newcomers and established staff members, 2) challenges and barriers encountered in the project, and 3) notions of good care. The interviews took place in the residential home, each one lasted between 45 and 60 minutes. All sessions were audio-recorded and transcribed verbatim in German.

Additionally, two focus group discussions were carried out, in order to get more insight into the experiences, discursive repertoires and ideas of that particular group (Silverman, 2013). One focus group consisted of six newcomers, the other of six established caregivers. The topics were 1) the newcomer's project 2) the collaboration between established staff members and newcomers, and 3) notions of good care. These sessions were also held in the residential home. They lasted between 90 and 120 minutes each, were audio-recorded and transcribed verbatim in German.

Data analysis

All ethnographic fieldnotes and transcripts were read and re-read by the researcher to develop familiarity with the data, and then analyzed using the constant comparative method (Brear, 2018; Glaser, 1965). Atlas.ti 10 software was used to generate *emic* and *etic* coding (Hammersley and Atkinson, 2019). First, open inductive coding was used to unravel the full range of observed practices, meanings and experiences During this stage, *emic* codes were applied (Hammersley and Atkinson, 2019). These codes consisted of words and descriptions used by the participants, such as 'rules', 'hard worker', 'collaboration'. Each code was compared to the others to identify differences, similarities and patterns. Some codes, such as 'collaboration' and 'teamwork', were merged together. In the next stage, *etic* codes, such as Bourdieu's notion of 'habitus' and Mol's notion of 'tinkering' were used as sensitizing concepts to get a certain kind of guidance to the data (Hammersley and Atkinson, 2019). With the combination of inductive and deductive analysis, a deeper understanding emerged from the

data. It appeared that care workers had to tinker with three different sets of values of care, i.e., institutional accountability or personal well-being, efficiency or carefulness, tranquility or dignity. To improve the *credibility* and *validity* of the study, a *member check* was conducted through respondent validation, and the preliminary main findings were presented to the participants (Brear, 2018). The participants affirmed that the findings reflected their views, feelings and experiences.

Ethical considerations

This study was approved by the Medical Ethical Review Committee of the Leiden University Medical Center in the Netherlands (code P16.087) and conducted according to the World Medical Association Declaration of Helsinki. The participants received oral and written information about the study. Their informed consent was given prior to the start of this study. All names used in this paper are pseudonyms. The data of this study was stored at The Hague University of Applied Science according to Dutch General Data Protection Regulation (Alkemade, et al, 2021).

RESULTS

The German residential home studied here provided care to psychogeriatric residents. From 2017 to 2019, the facility conducted a project called Asylum Seekers and Refugees as High Potentials in Germany, a Model Project in Social Affairs [*Asylbewerber und Flüchtlinge als Potenzialträger in Deutschland, ein Modellprojekt im Sozialwesen*, from now on referred to as AFP]. Sixty-nine first-generation immigrants from different countries, all from outside Europe, were recruited. Five different groups were admitted to five successive AFP projects, each one holding between 12 and 18 participants. Additionally, each project included an educational program, trainee for dementia assistants [*Auszubildende zur Dementzbegleiter/in]*. The residential home wanted to provide opportunities for first-generation immigrants to explore whether they would like to be trained as an occupational nurse, assistant, or helper/nurse aide in a residential home (table 1). The two-month 'Care for the Elderly' course covered basic knowledge and skills in psychogeriatric care. The third month involved an internship in a psychogeriatric ward. The residential home management supported the established staff by offering them a cultural awareness and sensitivity course called 'Care in a Cultural Context'. This course aimed to develop their intercultural competences, that is a collegial attitude of respect, regardless of gender, nationality, ethnicity, religion,

age or sexual orientation. All established staff participated in the course before the new workers began their internship. For this study, we chose the third AFP project group, when the residential home had already gained experience with two other groups of refugees and asylumseekers. This group consisted of seventeen newcomers from Syria, Iraq, Afghanistan, Azerbaijan, Togo, and Uganda. Among them were eight women and nine men, aged between 20 and 55 years with different educational backgrounds, such as technology, pedagogy or philosophy. Only three participants had obtained nursing experience.

The residential home residents were all white and native Germans. The established staff consisted of native Germans and caregivers with a migrant background, most of whom were born in East European countries, such as Poland, Bulgaria, Russia, and Turkey. None of the migrant workers had a bachelor degree in nursing. Most of them were nurse assistants or vocational trained nurses and worked in accordance with nursing level 2 or 3 of the German Qualification Framework (GQF) (see table 1). The native Germans worked in accordance with nursing level 3 to 4 of the GQF. They had lived in Germany between 20 – 30 years. Most of the native German care workers were women between the ages of 25 and 60 years.

Table 1: Nursing Care staff in Germany

English title	German title	German qualification level*	Training length (in years)
Baccalaureate-educated registered nurse	Bachelor Pfleger/in	6	4
Occupation Vocationally-trained nurse	Altenpfleger/in	4	3 – 5
Nurse assistant	Gesundheits-und Krankenpfleger/in	4	3 – 3,5 3 – 3,5
	Krankenpflegerhelfer/in	3	2
Nurse assistant Nurse aide	Pflegerassistent/in Altenpflegerhelfer/in	3 2	1-2 1-2
	Alltagsbegleiter für Menschen mit Demenz		12 weeks

*According to the German Qualifications Framework (GQF) (OECD, 2022).

Institutional accountability or personal well-being

During the in-class theoretical course and also during the focusgroup the newcomers shared their views regarding geriatric care. They all wished to enact good care by living up to the principles of equality and dignity, by placing themselves in the position of

the older people, by listening to them, showing respect and attending to residents' needs. These views were in line with the vision of the institution. However, in health care, shared values of care are never specific enough for a caregiver to know how to act in each situation. One of the newcomers said in the in-depth interview that he found it hard to know what was expected from him. During their internship, the immigrants realized that they needed to acquire a new habitus and' feel for the game' of care, in order to gain an understanding of how nursing works in daily practice compared to their familiar understanding of geriatric care from their home country. They also discovered that some of the established caregivers refused to work with them. For example, two caregivers with a Polish background were intolerant of their immigrant colleagues and completely ignored them. How caregivers tinkered with different values of care was influenced by the rules, regulations, and institutional protocols of the residential home. All newcomers agreed that the formal standards of the home were of high quality. They appreciated how those standards structured the daily practice—the punctuality of their established colleagues, their ability to organize and plan, and their professionalism. However, if different values were involved at the same time, protocols provided insufficient guidance and choices had to be made. The following situation illustrates that different values of care can work next to each other:

> *Birmasa, an established nurse, starts writing the nursing files. Mohammed looks in the cupboard and comes across a German game: Man, don't get annoyed [Mensch ärgere Dich nicht!]. He puts the box on the table and calmly takes a seat opposite Mr. Feiliger: "Please, Mr. Böhmig, take a seat and play with us." While the three men play the game, Mr. Feiliger keeps repeating its rules. Mohammed and the men laugh, and no one gets annoyed. (Fieldnote dd. 01.07.2018)*

In this situation, Birmasa and Mohammed engaged in different practices of care. By filling in the nursing reports in the office, Birmasa acted in accordance with the value of institutional accountability. The daily team meetings were structured around those reports for the purpose of continuity of care and information exchange. In turn, Mohammed, by playing a game of *Mensch ärgere Dich nicht* with two older residents, attended to another value of care, i.e., the improvement of personal well-being. He told us afterwards that it was common in his home country for older men to play board games. Thus, playing a game with the two residents was part of his *habitus*. In this situation, the two values of care, did not exclude each other, but were enacted by different workers simultaneously.

Efficiency or carefulness

For the newcomers, it was not always clear what the established staff expected of them. In the interview, one of the immigrants said that they received conflicting messages; the established staff members gave them strict orders but also expected them to take initiative. There were some established careworkers who appreciated the input of their new colleagues, but others were impatient. They accused their new colleagues of not taking initiative and not doing what they were told. Not knowing the German language was a main stressor. Some eventually decided to ignore the newcomers. They harboured feelings of resentment, some even feared to lose their job to them. The newcomers realized that due to the staff shortage they had to work hard and frequently on their own. One of the immigrants said that, although he had worked as a nurse for years, he knew he needed to adapt to a different way of caring. While in his home country the work of a nurse was mainly focused on medical aspect he now had to attend more to the general well-being of residents. Washing residents, for instance, had not been part of his professional habitus.

In the focusgroup, the established employees said that they delegated responsibilities to their new colleagues, but that this did not really relieve them of their more demanding duties. During fieldwork it was seen that Asmat tried to live up to their expectations to work efficiently. How this worked out is shown below:

> *It's 06.45 hours; Vera sighs: "Two colleagues just called in sick, so today we are with three instead of five care workers; Asmat, you must go to the right wing of the ward and wash all 15 residents. I will go to the left." Hastily, Asmat takes a washing trolley and pushes it down the corridor. He opens the door of Ms. Schweigers' room. "Good morning," he greets, with a big smile on his face, "did you sleep well?" Ms. Schweigers, sitting on the bed in her white pajama, smiles when she sees us. With a laugh, Asmat approaches her and takes both her hands. "Come," he says, quickly lifting her up from the bed, "let's dance." Holding her hands, he moves her arms up and down. She grimaces with big eyes, not saying anything. Quickly, Asmat catches her when she almost falls, and with a little push he flops her onto the bed again. Ms. Schweigers grins. "Ha-ha!" Asmat laughs loudly, "don't fall!" Then he swiftly pushes her pajama trousers to her ankles. "Let's take a 'pipi' [urinate]," he says. He raises her up again and holds her hands. Ms. Schweigers sighs. They shuffle to the bathroom together. Ms. Schweigers*

> *walks barefoot, with small steps; her underwear and trousers are around her ankles. In the bathroom, Asmat quickly puts her on the toilet and says again: "Just make a 'pipi.'" As she sits on the toilet, he quickly washes her face with a washcloth. "We need to hurry up," he says. He removes her pajamas, washes her body, and helps her into her jogging trousers and a t-shirt. Then, Asmat holds her hand and opens the door to the corridor. "Oh," he says, "wait." He quickly returns to the bathroom and comes back with a deodorant spray: "We forgot this." With a smile, he sprays the deo all over her clothes: "It's important that you smell clean." He grins, guides her to the breakfast table in the living room and then rushes to the room of the next resident. (Fieldnote, dd. 30.07.2018)*

In this situation, Asmat worked efficiently within the given time frame, just like his regular colleagues. However, zooming in a little closer, how Asmat provided his care was certainly not what he had learned. During his training the teacher had explained that care for people with dementia required a special approach:

> *'It is important when entering the residents' room to knock on the door and wait for a response, approach the resident by name and ask if she would like a cup of coffee. Know the resident's background and preferences. Ask if she can wash herself, assist if necessary. Try to empathize with, observe, listen to, understand and ultimately accept the resident as a person with their own personal identity, values and preferences'. (Respondent X, AFP Teacher)*

If we compare these instructions with the actual choreography of the interaction between Asmat and Ms. Schweigers, Asmat's care leaves a lot to be desired: he enters Ms. Schweigers room without knocking, almost lets her fall, has her shuffling with her trousers hanging around her ankles, washes her face while she is peeing on the toilet, sprays deo on her clothes. Although Asmat's attitude was cheerful and friendly, in his anxiety to do every task on his to-do list within the set time frame, he put Ms. Schweigers in improper positions that made her look undignified. We cannot be sure whether or to which extent Ms. Schweigers herself experienced this as such: she said nothing, only grinned and sighed. As many people with dementia, she was probably unable to express or even feel irritation, shame or fear (Moser, 2008). But for the quality of care, this is irrelevant: values such as carefulness, seemliness or decency hold, no matter if a client herself is unaware of the unseemliness of her situation, or if no one else is watching. Hence although Asmat was appreciated by

his colleagues for his ability to work efficiently, because they did not supervise his work, they did not notice how this went at the expense of his carefulness.

Tranquility or dignity

According to the mission and vision of the residential home, all caregivers need to recognize the dignity of older residents. Dignity is tied to the integrity of a human body and mind, but it also depends on the judgment of others what they perceive and experience as dignified or undignified behaviour and appearance (Nordenfelt, 2014; Rejnö, et al, 2020). Accordingly, if someone's dignity is violated, this affects not only the person involved, but also the tranquility of the people who are witnessing it, as the next case illustrates:

> *Mrs. Doldermann, a resident with curly gray hair, comes around the corner to the living room, screaming. Her face is red, her cheeks sunken, and her upper lip quivers before she starts yelling again. The shrill noise does not sound as if she is in pain. Suddenly she pulls off her joggers and t-shirt and throws them onto the floor. She now stands completely naked, her arms in the air. A few residents are staring at her. Mrs. Zierentz sighs and closes her eyes, Mrs. Mezel stands up and walks away. Mr. Vierbaum shouts: "No, no, not again! [Nein, nein, nicht wieder!]" as he looks to the ground with furrowed brow. Vera, one of the German careworkers, looks at Mrs. Doldermann and then walks past her to the corridor. Mrs. Doldermann pushes her clothes aside with her bare feet before sagging to the ground, her nude body now lying on the carpet. It seems as if she is in another world. After a while, Mr. Weiss, one of the residents, bends over her: "Dear, please come" [Liebe, bitte komm doch mal], he whispers. Slowly, she gets up. Mr. Weiss gently pats her shoulder. She turns her head toward him, her doll-like eyes distracted and confused. She slowly stands up and lets him guide her to the lounge. They then sit next to each other on the couch, she shivers, his hand gently takes her tiny one and soothes her, whispering: "shhhhh, shhhhh". (Fieldnote dd. 02.08.2018).*

During the fieldwork, I witnessed such anxiety attacks from Mrs. Doldermann several times. In these cases, staff often did not intervene. One time, two staff members stepped over her and simply continued on their way. In a conversation afterwards, Vera explained: "If we bring her to her room, she tends to cover herself

with feces, so we'd rather keep an eye on her in the living room." Mrs. Doldermann's nakedness and agitated behavior gave the impression of a complete loss of control. Witnessing the response of the other residents, it was clearly embarrassing and painful for them to watch how her agitation and nudity in public robbed Mrs. Doldermann of her dignity. However, when she covered herself with feces and became dirty [in her room], according to Vera and Brev, her dignity might have been affected even more. Moreover, the caregivers were the ones who had to clean up the dirt; therefore, they preferred to let her be nude on the floor for a while, even though it violated her dignity and affected the tranquility of the other residents. At first glance, this case seems to show that employees sometimes face so-called tragic dilemmas, that is: in situations in which it is inevitable, in the nature of things, that they have to choose between, to tinker with, two evils. In this situation: between accepting Mrs. Doldermanns's public nudity, hence a violation of her dignity, thereby breaking the tranquility of the other residents, or leaving Mrs. Doldermann in her room where she will smear herself and everything around her. The latter would also be a violation of her dignity although not in front of all the residents. But it would burden the care workers with the time consuming and nauseating task of cleaning up the dirty mess. However, constructing the dilemma in this way, blinds us (as it did Vera and Brev) to the fact that there were other options. To enact good care, Mrs. Doldermann's agitated behavior might have been responded to by someone guiding her to her room and stay with her to calm her down and prevent her from hurting or smearing herself. The problem, however, was that in this situation Vera and Brev had to care for 40 residents. Given the severe shortage of staff, the best care they could think of was simply to leave Mrs. Doldermann alone. The circumstances did not only make it impossible for them to, for instance, talk to her, sit with her, or give her a blanket. Due to work pressure they were not even able to imagine such options anymore. In this situation it was another resident who sat next to her and managed to soothe her a bit.

Evaluation

The AFP project was evaluated after three months between the project manager and the immigrant newcomers. The latter could start with an official nursing training if s/he had proven to be suitable and willing to do so. The project manager wanted to help realize the immigrants' wishes, even if they aspired to an entirely different career. However, she hoped they would choose a nursing career to help

relieve the labour shortage situation in the (geriatric) care sector. But despite the fact that they saw the residential home project as an opportunity for a new start, some newcomers quitted within a few days, while of the ones who did follow the entire three month project, only four started with the official nursing education. Two of them dropped out within a year, because of the stressful working conditions, the huge responsibilities, bad payment and difficulty combining the care for their children with the irregular shifts.

DISCUSSION

This paper offers insights in how established caregivers and immigrant newcomers enact care for residents with dementia in a German residential home. The results showed how they tinkered with different values when caring for the older residents. For the newcomers, working in a German residential home required them to adjust to a new caring field, which meant that some aspects of their previous education and (work) experiences were no longer useful. They realized that they needed to get a new 'feel for the game of care'. The analyses showed how they care for residents with dementia together with the established staff in situations in which different values were at stake and sometimes conflicted. Three modes of tinkering merged from the data, i.e. tinkering between the values of institutional accountability or person well-being, efficiency or carefulness, and tranquility or dignity. The results in this paper do not so much show the different *perspectives* on care of the participants, but rather the specific situations in which established staff and newcomers *enact* care. (Mol, et al, 2010; Moser, 2008; Pols, 2013; Struhkamp, 2004). The quality of care depends on the extent to which care workers are able to compromise between, or tinker with different values of care. This study indicates that the enactment of care must be discussed in the context of institutional work conditions, organizational structures and workforce processes. To gain a deeper understanding of the enactment of good care by the established caregivers and newcomers when caring for residents with dementia, Mol's concept of tinkering provided a useful lens through which to understand interaction in daily practice. However, the concept of tinkering has two limitations. First, the approach of tinkering can easily lead to ignoring the influence of aspects of the wider context. During the time of this research, for instance, the upcoming anti-immigrant rhetoric in Germany resonated in the day-to-day interactions on the work floor of the residential home. Research has shown that discrimination and racist practices take place in German society at large, as well as in (health care) organizations such as

German residential homes (Ham, 2021a; Ratfisch and Schwiertz, 2016; Schilgen, et al, 2019; Ulusoy and Schablon, 2020). The second limitation of the concept of tinkering is that it does not consider aspects such as the impact of organizational power and institutional structures. A closed ward within a residential home for people with dementia is a protected and isolated environment that prevents others from entering easily, while what happens inside does not easily become known to the outside world (Olakivi, 2017; The, 2008). In fact, the layers of protection surrounding the care of people with dementia, including the structural pain of caregivers that management does not really care for them, as I showed in other articles (Ham, 2020; 2021a; 2021b) do not allow the deterioration of care to be brought to the attention of a higher political level. While an ageing population and a structural shortage of caring staff in this German facility created a demanding workload, care providers felt that their voices had little or no weight, which led to a further lack of possibilities to improve geriatric care. If no one feels fully responsible for the quality of care as a whole and for institutional geriatric care in particular, the risk of further indifference toward geriatric care increases. When the focus of the institution is too much on efficiency it can create a system that undermines care workers' morals, making them do their work routinely and without much thought. Structural labor shortages and organizational constraints can hamper care workers' vision of possibilities to improve care. As a result, caregivers in a residential home who are not given the opportunity to reflect on the care given in practice are not inclined to disrupt the process of further dehumanization, even though they witness it daily (McHugh, et al, 2011). Sometimes, caregivers face dilemmas when they lack time to give attention to the older residents due to a structural shortage of staff or a lack of sufficiently skilled or experienced personnel. In the German residential home studied here, half of the personnel consisted of experienced but unskilled labor migrants from Eastern Europe and of recently arrived refugees who did not have the required qualifications. The latter were also not familiar with the increased complexity of the residents' conditions. This had consequences for the quality of the daily care. A high workload resulted in a higher absenteeism due to sickness of staff. Employees who could no longer cope with the demanding workload and felt that their voice did not matter became demotivated. Staff time was taken up by basic care, and agitated residents were not given enough time or attention. No matter how hard and efficient the care workers worked, their job was never finished. Because they were not confident they could change the situation, they became indifferent and less committed (Noordegraaf and Steijn, 2013; The, 2008). Thus, although the established caregivers and the newcomers showed a willingness

to enact good care in daily practice, their attempts were hindered by the dynamics of the organization and structural limitations as well as the influence of the wider societal developments (McHugh, et al, 2011). Having an appreciative support system for newcomers as well as for the established care workers is needed for them to be able to cope with the high workload, to foster team collaboration and the enactment of good care. Finally, the strength of this study is that we not only spoke with the established staff and the newcomers about their *perspectives* on care, but that we also observed their behaviour, their actual enactment of care. Although this research is part of a larger project and a similar study was conducted in a Dutch residential home, these results, having focused on only one residential home in Germany, do not permit the generalization or transferability to other German residential homes. However, the different methods of this ethnographic research made it possible to facilitate transparency of the analysis and to strengthen the study's trustworthiness.

CONCLUSION

This article described how first-generation immigrants and established caregivers in a residential home in Germany tinkered between different values to enact good care for residents with dementia. By zooming in on the enactment of care, we gain a better understanding of how caregivers tinker between values of care that matter most at that particular time and place. Some values come to the fore, while others recede into the background. This study has shown that enactments of good care may be multiple and relational, for example, how the value of institutional accountability may go hand in hand with the value of personal well-being, but also how efficiency may undermine carefulness. It showed how an excessive workload might lead to the sacrifice of several values of care, such also violating the dignity and disturbing the tranquility of residents. Finally, it indicated how feelings of powerlessness may lead to thoughtless behaviour and to the inability of careworkers to envision better ways to enact care at that particular time. Institutional constraints can therefore severely influence the interactions between established staff and newcomers and thus their enactment of care for residents with dementia. We recommend that policymakers on the (national) macro- and (institutional) meso-level improve working conditions, facilitate team collaboration, set up a support network for both established workers and newcomers.

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