Moral learning through caring stories of nursing staff: OK

Eijnde, C. van den; Dohmen, M.D.; Groot, B.C.; Huijg, J.M.; Abma, T.A.

Original Manuscript

Moral learning through caring stories of nursing staff

Nursing Ethics
2024, Vol. 31(4) 572–583

DOI: 10.1177/09697330231218345
journals.sagepub.com/home/nej
Sage

Charlotte van den Eijnde
Leyden Academy on Vitality and Ageing; Leiden University Medical Center

Marleen DW Dohmen
Leyden Academy on Vitality and Ageing; Leiden University Medical Center

Barbara C Groot
Leiden University Medical Center; Vrije Universiteit Amsterdam

Johanna M Huijg
Leyden Academy on Vitality and Ageing; Leiden University Medical Center

Tineke A Abma
Leyden Academy on Vitality and Ageing; Leiden University Medical Center

Abstract

Background: Implementing person-centred care (PCC) in nursing homes is challenging due to a gap between theory and practice. Bridging this gap requires suitable education, which focuses on learning how to attune care to the values and preferences of residents and take moral, relational, and situational aspects into account. Staff's stories about the care they provide (i.e. caring stories) may deliver valuable insights for learning about these aspects. However, there is limited research on using staff's narratives for moral learning.
Objective: This study aims to provide insight into the perspectives of nursing staff on using their caring stories to learn about PCC.
Research design: In this qualitative research, we conducted two rounds of interviews with 17 participants working in nursing homes. We wanted to obtain nursing staff's perceptions of working with their caring stories and the impact on PCC.
Ethical considerations: Participation was voluntary, and participants provided written consent. The study protocol is approved by The Institutional Review Board of the Medical Ethical Committee Leiden-Den Haag-Delft.
Findings: Working with caring stories enables nursing staff to provide PCC and improves job satisfaction. It increases awareness of what matters to residents, fosters information rich in context and meaning, and enhances voice and vocabulary. Through in-depth team reflections, nursing staff discussed the significant moments for residents, which centralizes the discussions on the moral quality of care.

Corresponding author:
Charlotte van den Eijnde, Leyden Academy on Vitality and Ageing, Rijnsburgerweg 10, Leiden 2333 AA, The Netherlands.
Email: eijnde@leydenacademy.nl

Discussion: Working with caring stories fosters dialogue on PCC and enhances reflection on ethical situations in daily encounters, contributing to the moral development of nursing staff. Putting nursing staff's narratives at the centre of learning suits their daily practice and intrinsic motivation. Therefore, the outcomes of this study are an addition to the existing literature about using narratives in long-term care.
Conclusion: Using nursing staff's narratives contributes to PCC and positively impacts nursing staff. We recommend using staff's caring stories as a vehicle for moral learning in the transition to PCC.

Keywords
Nursing home, person-centred care, nursing staff education, moral learning, narrative ethics

Introduction

Over the last decades, the literature on person-centred care (PCC) in nursing homes has considerably grown. This growing interest is due to the cultural shift in long-term care from a biomedical approach, focussing on diseases, towards a person-centred approach, focussing on values and preferences. Following Goodwin's[1] definition of PCC, personal values and preferences should guide all aspects of the care provided, supporting individuals' quality of life. Furthermore, relationships and collaboration between care-receivers, nursing staff, and their significant others play an important role in PCC. This definition implies that good care has a different meaning for every individual, with the aim that people receiving care in nursing homes can live their lives as they wish.[2]

Despite the growing body of literature and the fact that care organisations have embraced the idea of PCC in their communication and policy, applying PCC in practice takes time and effort.[3] Studies on implementing PCC point to a gap between theory and practice.[1,4–7] These studies show that positive attitudes of organisation and staff, communication and clarity about the topic, sufficient staffing resources, and education and training play an important role in implementing PCC.[1,4,5,8] Specifically, education and training should focus on staff's understanding and commitment to PCC and their competencies to attune care to personal values and preferences[1,9]

Following care ethics,[10,11] caring is considered a moral-relational and contextually-embedded practice. Similar to the definition of PCC,[1] care ethics describe good care as continuously attuning what is done (or not done) to the values and preferences of care-receivers, relate this to the values and preferences of significant others, as well as their own, and take into account what happens in the environment.[12] Good care goes beyond following moral rules and principles; it is a relational affair and requires intersubjective agreement. Care ethicists Leget, Van Nistelrooij, and Visse,[12] describe that 'in practices, the morally good can emerge and be experienced by those involved' (p. 22).

In this moral landscape, it is essential for nursing staff to develop a person-centred ethics of care.[13–15] In other words, they need to learn to examine what matters to residents, their significant others, and themselves, and take this into account in providing care.[16,17] The literature shows that this requires specific competencies. Firstly, relational competencies, as PCC is always relational.[1] Education, thus, should focus on human factors and complex intra- and interpersonal relationships in the nursing home.[18,19] Secondly, moral competencies, as nursing staff face various ethical issues daily.[20,21] Education should focus on listening and observation skills, communication, empathy, professional growth, increased capacity for reflection, and shared decision-making.[22] Finally, from an ethics of care theory, good care is more than rule-based behaviour; different situations with different people require a different approach to good care every time. Therefore, learning is, besides moral-relational, also situational since the learning process always occurs in a concrete situation wherein a particular person needs care in a complex context subject to change.[23]

An appropriate starting point for learning these competencies could lay in narratives about care practices (i.e. caring stories).[24,25] Narrative ethics literature suggests that caring stories are suitable for nursing staff to understand what matters to residents and to what extent their care practices meet (or not meet) residents' values and preferences in a specific situation.[26–29] Furthermore, the literature suggests that working with caring stories enhances the development of nursing staff's moral beliefs and identity,[28–30] their clinical imagination, empathy for patients, awareness of the ethical dimensions of clinical situations, and capacity for attention.[24,25]

To this end, caring stories may support nursing staff to attune care to the values and preferences of residents and take moral, relational, and situational aspects into account when providing care.[30–33] In this light, caring stories may be an important vehicle to implement PCC in nursing home care. However, as we know, nursing staff participating in studies on using narratives for PCC only use residents' narratives. Also, these studies do not provide knowledge on the impact of working with narratives on nursing staff and teams and their perceptions of using narratives for PCC. Therefore, this article aims to provide insight into the perspectives of nursing staff who worked with their caring stories to learn about PCC.

Methodology

Context

Data collection for this study occurred in the context of a larger 2-year project (2020–2022) in the Netherlands. The overall aim of this project was to foster a mutual learning process among nursing staff to improve PCC. To reach this aim, we adopted a design inspired by a responsive evaluation approach. In responsive evaluation, the people whose work or life is central are engaged in a collaborative inquiry to enhance their personal and mutual understanding as a vehicle for practice improvement.[34] The researcher acts as a facilitator rather than an expert standing above the people in practice.

To this end, the researchers (CE and MD) and nursing staff collaborated on developing an approach to work with caring stories as part of the everyday practice and use these narratives for (1) attuning care to the values and preferences of residents, (2) reflecting on care in teams, and (3) evaluating care on an organizational level. During the project, a process was designed for nursing staff to (a) be aware of their experiences in the process of caring, (b) express these experiences in written text or images (i.e. caring stories evoked by the open-ended question: 'What did you do or experience today that stayed with you? What happened, and how did it make you feel?'), (c) share their caring stories in a software application, and (d) use them to reflect on and co-create PCC. In order to cooperatively develop an approach suited to the dynamic and complex reality of psychogeriatric care, there were no predetermined requirements regarding frequency, time, and place for nursing staff to share their caring stories. Instead, an open and flexible approach was taken, stimulating and coaching care staff to share their narratives whenever possible, often between work tasks. During the project, researcher and participant observations and reflections were documented in field notes.

The project was carried out in cooperation with the psychogeriatric wards of two nursing homes in the Netherlands. In nursing home A, the daily care team cared for twenty-six residents. The team comprised around twenty-five permanent staff members, several students, and several flex workers who were an important part of the team. A team manager guided the team. Nursing home B was small-scaled; the daily care team cared for eight residents. The team consisted of eight permanent staff members and one apprentice and was self-guiding, supported by a location manager.

Participants

In total, seventeen members of the daily care team (n = 10 in nursing home A, n = 7 in nursing home B) participated in co-developing the approach to work with caring stories and the interviews. Participants were aged between 25 and 57, and fourteen were female. They were in the function of an activity coordinator (n = 2), certified nursing assistant (n = 1), licensed practical nurse (n = 8) or were in training to become a licensed practical nurse (n = 4).

Data collection

Semi-structured interviews were conducted to deepen our understanding of staff's perceptions of working with caring stories and learning about PCC. They took place at two points in time: one and 2 years after the project's initiation. Both interview topic lists (Appendix 1) were complemented by visual methods (Appendix 2–4) as elicitation tools to gain more insight into participants' experiences. Using a creative method makes it easier for participants to talk about complex subjects and can help them articulate and uncover underlying ideas.[35] Field notes on researcher and participant observations and reflections were used for the interpretation of the interview findings.

Interview 1: January 2021. After 1 year, the working with caring stories approach was still in the development phase. Therefore, interviews focused on nursing staff's expectations of working with caring stories and the impact on PCC. In this way, the approach could be adjusted to their needs and daily routines. As a visual elicitation tool, an image of a winding road was used, symbolic for the course of the project. Participants were asked to write on this image, detailing (1) their experience of working with caring stories thus far, (2) facilitating and limiting aspects in working with caring stories, (3) their ideas about the ideal outcome of the project, (4) what they would need to learn to reach this ideal situation, and (5) expected facilitating and limiting aspects in reaching this ideal situation. Their written answers formed the starting point for the interview, which was further guided by the topic list that mainly focused on the elicitation of specific moments in which working with caring stories did or did not add value to nursing staff's work.

Interview 2: January 2022. After 2 years, the project was in its final phase. Therefore, the interviews focused on nursing staff's experiences with working with caring stories and the impact on their PCC practices. Due to time constraints, duo interviews were chosen. Again, a visual elicitation tool was used, a poster stating several practical ways to apply the method (i.e. to know how someone is doing, to reflect on the collaboration, to get more insights into experiences of significant others). Participants reacted to the poster, writing down their first reactions. Their reactions formed the starting point for the interview, which was further guided by the topic list that mainly focused on the meaning of the approach in nursing staff's work. The interviews were conducted by CE and MD jointly. Given the practical nature of the information on the poster, it was assessed that any information about the impact of working with narratives would stem from participants themselves, and would not be prompted by the poster.

Analysis

The transcripts of the audio-taped interviews were analysed manually, using an inductive style of thematic analysis.[36] First, CE and MD screened the data separately in detail. Then, they categorised and coded themes recurring from the data, moving beyond the semantic content and delving into underlying ideas, patterns, and assumptions. CE and MD then jointly mapped the data, distinguishing themes and subthemes as the last step in preparation of the final analysis. The final analysis was in-depth. The themes and subthemes identified by CE and MD were compared and discussed until consensus was reached. During this process, the other authors (BG, JH, and TA) acted as critical friends, asking reflective questions and providing feedback.

Ethical considerations

This study was reviewed and declared not subject to the law on research involving human subjects by the Institutional Review Board of the Medical Ethical Committee Leiden-Den Haag-Delft and was registered under number N20.095. The protocol was assessed and considered compliant with scientific due diligence. All participants provided written informed consent.

Findings

This study aims to give insight into the perspectives of nursing staff on using their caring stories to learn about PCC. Their perspectives are structured in four themes: (1) increased awareness of what matters to residents, (2) enriched context and meaning, (3) voice for nursing staff and thicker vocabulary, and (4) in-depth team dialogue and reflection. Finally, considerations for working with staff's caring stories are reported.

Increased awareness of what matters to residents

Long-term care is a complex working environment with many challenges, including time pressure and minimal staffing resources. These challenges put daily care routines at the forefront. During the interviews, nursing staff indicated that they felt working with caring stories helped them be more aware of what mattered to residents. It offered the opportunity to discuss important issues in resident's lives, like the following example:

> *"I became more aware, like: oh right, this is important, even if it's small, for example residents that enjoy a movie together. […] But you'll also recognize the less pleasant things. And it's nice to discuss with colleagues, whether they see it the same way and whether we can do something about it."* (participant 1)

Nursing staff felt that sharing experiences in text or image was one of the mechanisms behind their increased awareness of what mattered to residents. While informal communication between nursing staff frequently involves sharing experiences about encounters with residents and significant others on the ward, these experiences are often forgotten or not seen as necessary to share in text or images. As a consequence, they get lost over time, even though they contain relevant information for good care. Nursing staff stated that when sharing caring stories became part of their daily routines, it forced them to be attentive to what happened during the workday, leading to even greater awareness of what mattered to residents.

> *Interviewer: "Suppose others start working with this, which part of working with narratives would you recommend to them?"*
>
> *Participant: "The part where you write down the stories and become aware […] You always have experiences. But becoming more aware of them and writing them down for others to read, I think that part is really important."*
>
> (participant 2)

Translating experiences into caring stories requires a process of meaning-making and encourages nursing staff to ask reflective questions, such as 'What happened and how do I feel about it?' 'How did the resident experience the situation?' Asking these questions is necessary since it helps to understand the situation and give meaning to it, advancing it from an observation to a meaningful story.

Being more aware was beneficial for PCC in many ways. Foremost, it helped nursing staff look differently at their work. They gained a greater overview, which enabled them to look at situations from a distance and

feel more in control. This made it easier to take on a more reflective attitude and derive meaning from narratives. They questioned each other about the rightness of the used approaches and created opportunities to provide care aligned with the residents' wishes and needs.

> *"I learned something because it made me take a second look at situations. […] A way of looking at some things more calmly. And not just on autopilot."* (participant 3)

This awareness also brought more job satisfaction and work pleasure. It evoked feelings of pride because the realisation arose that their work was extraordinary and they could make a significant contribution to the well-being of residents, which motivated them to create more of those special moments.

> *Participant: "I do like it a lot now. And also, but I believe I also wrote that on that sheet, that you really start reflecting on the experiences we normally take for granted. That we're now sharing them with others and even writing them down so that we can actually think about them..."* (participant 2)
>
> *[...]*
>
> *"Yeah, just the fact that I really start noticing things more now. But also, seeing the emotions behind situations a bit better, even from residents" […]*
>
> *Interviewer: "What kind of a difference does this make for you?"*
>
> *Participant: "Well, what it brought me is that I... that maybe through that, I can now enjoy certain moments more and not take them for granted."* (participant 2)

Enriched context and meaning

A significant part of a biomedical approach is that daily reports written by nursing staff are focused on medical information and factual descriptions. Generally, there is no room for nursing staff's point of view. Although daily reports provide information about *what* type of care is provided, they do not offer insight into *how* it is provided and, therefore, lack context and meaning that can provide directions for PCC.

In our method, nursing staff were asked to answer an open-ended question, including prompts challenging them to share their narratives: 'What did you do or experience today that stayed with you? What happened, and how did it make you feel?' To answer this, they could share anything they considered important. Nursing staff expressed this led to information rich in context and meaning about PCC, serving as examples and inspiration, which eventually helped them to provide care that fits the residents' needs and wishes:

> *"I do think colleagues are made to think more like: 'Okay, how did that person experience the situation, and how did I experience it?' Because normally, you just see 'the resident ate well' in the reports. [...] But then, of course, there's a lot more… You are much more aware of what you experienced with that person during your shift. And how you think he or she experienced it. [...] So if you report from your experience, then you are really thinking about the person and your experiences with that person. [...] I think that will get you a lot more than 'the resident ate well, and we gave him clean pants."* (participant 4)

Besides that, situations were described as richer, and new situations that previously had no place were now shared. This resulted in an even richer context, including more meaningful information about what PCC for residents entailed. In the end, this enhanced a more person-centred environment. Consider the following example, in which a care professional played music of her preference on the ward:

Participant: "Emma [pseudonym of a resident] came into the kitchen. And I said 'oh, let me turn down my music.' But she said 'no, no, no.' [...] And then Emma came towards me and took me in her arms to dance together.

That was so much fun. And moments like that, that's what really matters. [...] And it was actually a surprise to me that they liked my music. I never would have suspected them to rock out to it like they did. [...] Previously, I might have let moments like that pass by rather quickly. But you wrote it down later on, right?" (participant 2)

Participant: "Yes, I did. That's the difference. Previously, I might have written down: 'Emma enjoyed dancing' or 'enjoyed the music'." [...] *"Normally, we wouldn't have given it a second thought."* (participant 3)

Participant: "But now, we go into more detail." (participant 2)

Increased voice and vocabulary

Discussions about good care are often problem-focused and centred around big issues such as end-of-life and safety. In these discussions, the opinion of nursing staff is rarely asked. This means they often do not have a voice and remain silent, whereas they spend the most time with the residents. Nursing staff felt that to provide PCC that attains the residents' needs and wishes, their voices must be heard. They indicate that sharing caring stories allowed for subjectivity. This created a feeling of empowerment; they could now share those situations that were important to them in their work in their way. These were, foremost, the positive and small, meaningful events in residents' daily lives:

"Anyway, it is more enlightening how someone is feeling now. That is much more important than physical information. These physical things are always a part of care, but they are no longer in the spotlight. […] *When I have a few days off and then come back, I read the reports because I want to know how the residents have been doing. I find it the most important to read about their pleasant experience and their shitty day or their angry mood. And not about their infected toe or whether they suffer from diarrhoea."* (participant 5)

Moving away from only discussing and solving medical issues towards describing small, meaningful events fits well with the nursing staff's vision of good PCC and their intrinsic motivation, which is about relationships and contributing to a good life for the resident. Working this way made it possible to look differently and more openly at their work, leading to higher fulfilment; they reported enjoying their work more and feeling more proud.

Nursing staff shared that it is not always easy to be open about situations and to share their feelings. They could not always find the words to describe what they were going through. Working with narratives helped them in finding these words. Through practice and examples of colleagues, they got a more extensive vocabulary, and their voice and vocabulary got thicker, making it easier to make sense of their narratives and write about their vision of situations on the ward. Writing down their feelings also allowed them to distance themselves from the situation, making it easier to reflect on their actions and ultimately provide PCC.

Participant: "At first I thought, yes, lovely, pictures! I will only take pictures. But now I see it is better to write the whole story. A short story, though, but yes. Like with Mr. Hendrik [pseudonym of a resident], I found it quite difficult to bring him away to the clinic, so then I thought, I'm going to write it down ... Then I can let it go. So, I don't know if everyone works that way, but it helps me to process these things. [....] I don't know how to describe that, but..." (participant 6)

Interviewer: "Like a kind of diary?"

Participant: Yes, a moment in which you'll think: let me write it down so I can move on." (participant 6)

In-depth team dialogue and reflection

A shared view amongst the nursing staff was that only sharing and reading caring stories is insufficient; they felt that when you work with them, the essential next step is to start a dialogue within the team about these caring stories.

By centring caring stories in team reflections, these reflections became deeper and created more openness in the team. Team reflections started by reading the caring stories and generated different perspectives. This relieved the pressure to agree, resulting in more equality within the team and the variety of perspectives spurred a process of moral learning in the team as members wanted to learn more about each other's views on situations. More equality contributed to a safe, open space where everyone listened closely and created a climate for learning and mutual understanding. In addition, it immediately became clear from their caring stories what the most prevailing issues were. To this end, nursing staff felt these in-depth reflections helped providing PCC.

> *"Oh yes, it also provides recognition and a better understanding.*
>
> *[...] Also, as a team, recognition of your colleague.*
>
> *[...] and you can learn from each other. How is your colleague dealing with something?"* (participant 7)

Next to recognition, nursing staff felt acknowledged, as their narratives were the source of the team reflections, and the emerging topics from the caring stories became the main subject of reflection. This gave them the feeling of being taken seriously and having an influence on their daily work practice, as their perspectives on situations were now the most important.

> *Participant: "It is also about; what does a good life mean to you? How do you handle it, in your own way? And I love that you can do it in your own way. You're not restricted; everything is allowed."* (participant 8)
>
> *Interviewer: "Oh, you mean that we gave you space to approach it* [working with caring stories] *in your own way?"*
>
> *Participant: "Yes, exactly. [...] I really liked that. Nothing was rigid with rules, but you could experience it all in your way; your own stories were important. So I just kept doing it my way, and that's why it has also made me feel good. [...] So everyone can use their own qualities."* (participant 8)

Considerations for working with caring stories

To obtain the goal of working with caring stories, namely, PCC for residents in nursing homes, it is also essential to reflect on the nursing staff's considerations for this innovative way of working.

Sharing caring stories besides the mandatory daily reports causes a double workload for nursing staff. Nursing staff reported this as a dilemma based on short-term and long-term investments. On the one hand, they were motivated to work with caring stories to improve PCC long-term. On the other hand, hours spent capturing and sharing caring stories, on top of writing the daily reports takes time away from the residents.

> *"We write daily reports in ONS* [daily reporting system] *every shift and sometimes multiple times a shift, and now we also have to write something in SenseMaker* [caring stories software] *separately. […] So yeah, it just takes time. And that is a shame sometimes, because then you can't spend that time on a resident."* (participant 5)

Nursing staff indicated that stability within a team is a prerequisite for reflexive dialogues based on caring stories. During turbulent periods, such as conflicts or high staff turnover, it was challenging to prioritize

sharing caring stories. Additionally, they felt everyone on the team needed to support working with caring stories to benefit the residents. This is seen as impossible when there are frequent staff changes or when not everyone is on board with using narratives. According to the nursing staff, stability contributes to reflection and learning, which becomes easier when there is consistency in staffing resources and motivation within the entire team.

> *Interviewer: "And how would you like to go about this, encouraging colleagues to learn from each other's experiences?"*
>
> *Participan: "I think, first, you need to have a stable team. […] If I look at the team upstairs now, they're becoming somewhat more stable. More permanent staff has joined, you know. The turmoil is a bit less, apart from the occasional absences due to sickness, of course. And that's a prerequisite for being open to learn from each other, of course."* (participant 4)

Finally, working with caring stories is a (moral) learning process that requires time and focus and is, therefore, something that takes effort to implement on a ward. Nursing staff preferred that this learning and implementation process is facilitated by someone outside the team who is already familiar with this way of working and can function as a coach.

Discussion

This study aimed to give insight into the perspectives of nursing staff on using their caring stories to learn about PCC. Sharing caring stories by staff members can contribute to moral learning and the development of their moral competencies because it urges them to interpret the life worlds of older people and how their care and their relationship with the resident contributes to the well-being of the residents. The essence of moral learning comes through sensemaking of what matters in care work with three main elements: stories can capture the moral complexity of a care situation, stories capture the context of the situation, and stories reveal the identity of residents and nurses, their relationship and the values that matter. These aspects are the core elements of moral learning concerning PCC. Caring stories provide a learning framework through which this can occur.

Making sense of and giving meaning to narratives with caregiving enables nursing staff to provide better PCC; it makes them more aware of what matters to residents, fosters a richer context and meaning, gives them a voice and contributes to profound team reflections on good care. Because they now had a voice and in-depth team reflections emerged, the conversation about the moral quality of care became much more central and richer. The variety of perspectives among staff spurred the learning from and with each other as part of and embedded within daily practice. Consequently, this enabled them to learn more and engage in more meaningful discussions about good care, eventually helping them to provide PCC. The positive outcomes for nursing staff were increased job satisfaction, a sense of control over their work, empowerment, and strengthened team cohesion. In short, sharing staff's caring stories fostered moral learning.

Our study shows that sharing caring stories contributes to the moral development of nursing staff, helping them attune to the wishes and needs of residents by starting a dialogue on what good PCC entails for residents. They became more aware of the ethical situations in their daily encounters with residents and gained a better understanding of them. Although narratives around illness[33,37–39] and narratives in clinical case deliberations are not new,[39] literature shows a lack of attention to the everyday ethical and moral dilemmas in long-term care for residents.[40–42] Furthermore, when there is attention to moral issues on the work floor, this is often about major issues around safety and end-of-life decisions. Such discussions tend to be verbal and problem-focused, which does not fit with the preferred way of learning among the nursing staff.[42] Research shows that moral learning in long-term care needs to focus on everyday ethical issues[43]; nursing staff needs to learn to recognize and identify moral issues in the mundane

moments, and make them subject to reflection.[42,44] Therefore, our caring stories approach is a significant addition to the available methods for moral development. It is an accessible way of working, as the different values, feelings and thoughts of those involved gain a hearing, which deepens team reflections about PCC.

The literature shows growing interest in using narratives in long-term care.[45] In practice, residents' narratives are primarily the sources for improvement of the quality of care. At the same time, PCC and quality of care are created in the relationship between nursing staff, residents, and their significant others, wherein the narratives of all these stakeholders should be considered.[10] Therefore, the outcomes of this study are an addition to the existing literature and practical knowledge about using narratives in long-term care, showing that nursing staff's narratives can be used for moral learning about PCC and, therefore, improve the quality of care.

This study has both limitations and strengths, one of the limitations is that the study was conducted in two nursing home locations in the Netherlands. This may limit the generalizability of the findings to other settings or contexts. However, this small-scale approach also allowed for a more in-depth exploration and understanding of the topic.[46] Another limitation is that the researchers responsible for developing the caring stories approach also conducted the interviews, which could introduce bias. On the other hand, the established relationship between the researchers and participants can be seen as a strength because it fostered in-depth understandings of the studied context.[47]

Further research is recommended to implement and evaluate working with staff's caring stories in multiple nursing homes to nuance and strengthen the validity of the findings. We can conclude from this study that using nursing staff's own narratives and caring stories fostered moral learning and contributed to PCC because the moral virtues of Tronto,[10] like attentiveness, increased. Like Rita Charon states, stories contribute to better care because staff develops clinical imagination, deepens empathy for patients, becomes more awareness of the ethical dimensions of clinical situations and develops the capacity for attention.[24,25] In addition, sharing staff's caring stories positively impacts on their work satisfaction because it gives them a voice and fosters their empowerment. We, therefore, recommend using staff's caring stories in the transition to PCC for older people in nursing homes.

Acknowledgements

We would like to extend our grateful thanks to all the nursing staff of the two nursing homes who contributed to this study.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This work was supported by the Dutch Ministry of Health, Welfare and Sport [329397].

ORCID iDs

Charlotte van den Eijnde https://orcid.org/0000-0003-3170-1822
Marleen DW Dohmen https://orcid.org/0000-0002-4503-5464
Barbara C Groot https://orcid.org/0000-0001-7495-3048

Supplemental Material

Supplemental material for this article is available online.

References

1. American Geriatrics Society Expert Panel on Person-Centered Care. Person-centered care: a definition and essential elements. *J Am Geriatr Soc* 2016; 64(1): 15–18.
2. Koren MJ. Person-Centered care for nursing home residents: the culture-change movement. *Health Aff* 2010; 29(2): 312–317.
3. Stoop A, Lette M, Ambugo EA, et al. Improving person-centredness in integrated care for older people: experiences from thirteen integrated care sites in Europe. *Int J Integrated Care* 2020; 20(2): 1–16.
4. Chenoweth L, Jeon Y, Stein-Parbury J, et al. PerCEN trial participant perspectives on the implementation and outcomes of person-centered dementia care and environments. *Int Psychogeriatr* 2015; 27(12): 2045–2057.
5. Colomer J and De Vries J. Person-centred dementia care: a reality check in two nursing homes in Ireland. *Dementia* 2016; 15(5): 1158–1170.
6. Kloos N, Drossaert CHC, Trompetter HR, et al. Exploring facilitators and barriers to using a person centered care intervention in a nursing home setting. *Geriatr Nurs* 2020; 41(6): 730–739.
7. Oppert ML, O'Keeffe VJ and Duong D. Knowledge, facilitators and barriers to the practice of person-centred care in aged care workers: a qualitative study. *Geriatr Nurs* 2018; 39(6): 683–688.
8. Moore L, Britten N, Lydahl D, et al. Barriers and facilitators to the implementation of person-centred care in different healthcare contexts. *Scand J Caring Sci* 2017; 31(4): 662–673.
9. Farre A and Rapley T. The new old (and old new) medical model: four decades navigating the biomedical and psychosocial understandings of Health and illness. *Healthcare* 2017; 5(4): 88.
10. Tronto JC. Creating caring institutions: politics, plurality, and purpose. *Ethics Soc Welfare* 2010; 4(2): 158–171.
11. Tronto JC. Protective care or democratic care? Some reflections on terrorism and care. In: Proceedings of the SIGNAL, Brussels, Belgium, 23 September 2016.
12. Leget C, van Nistelrooij I and Visse M. Beyond demarcation: care ethics as an interdisciplinary field of inquiry. *Nurs Ethics* 2019; 26(1): 17–25.
13. Britten N, Ekman I, Öncel N, et al. Learning from Gothenburg model of person centred healthcare. *Br Med J* 2020; 370: m2738.
14. Ekman I. Practising the ethics of person-centred care balancing ethical conviction and moral obligations. *Nurs Philos* 2022; 23(3): e12382.
15. Dellenborg L, Wikström E and Andersson Erichsen A. Factors that may promote the learning of person-centred care: an ethnographic study of an implementation programme for healthcare professionals in a medical emergency ward in Sweden. *Adv Health Sci Educ* 2019; 24(2): 353–381.
16. Abma TA, Molewijk B and Widdershoven GAM. Good care in ongoing dialogue. Improving the quality of care through moral deliberation and responsive evaluation. *Health Care Anal* 2009; 17(3): 217–235.
17. Abma TA and Widdershoven G. Dialogical ethics and responsive evaluation as a framework for patient participation. *Am J Bioeth* 2014; 14(6): 27–29.
18. Cook NF, Brown D, O'Donnell D, et al. The person-centred curriculum framework: a universal curriculum framework for person-centred healthcare practitioner education. *Int Pract Develop J*. 2022; 12(4): 1–11.
19. Fawcett TJN and Rhynas SJ. Re-finding the 'human side' of human factors in nursing: helping student nurses to combine person-centred care with the rigours of patient safety. *Nurse Educ Today* 2014; 34(9): 1238–1241.
20. Munkeby H, Moe A, Bratberg G, et al. 'Ethics between the lines' – nurses' experiences of ethical challenges in long-term care. *Glob Qual Nurs Res*. 2021; 8: 1–11.
21. Preshaw DH, Brazil K, McLaughlin D, et al. Ethical issues experienced by healthcare workers in nursing homes: literature review. *Nurs Ethics* 2016; 23(5): 490–506.
22. Charon R and DasGupta S. Editors' preface: narrative medicine, or a sense of story. *Lit Med* 2011; 29(2): vii–xiii.
23. Abma TA. Situated learning in communities of practice: evaluation of coercion in psychiatry as a case. *Evaluation* 2007; 13(1): 32–47.

24. Charon R. What to do with stories: the sciences of narrative medicine. *Can Fam Phys Med*. 2007; 53(8): 1265–1267.
25. Charon R. *Narrative medicine: Honoring the stories of illness*. Oxford: Oxford University Press, 2008.
26. Abma TA, Bruijn A, Kardol MJM, et al. Responsibilities in elderly care: Mr Powell's narrative of duty and relations. *Bioethics* 2012; 26(1): 22–31.
27. Goldsteen M, Abma TA, Oeseburg B, et al. What is it to be a daughter? Identities under pressure in dementia care. *Bioethics* 2007; 21(1): 1–12.
28. Baldwin C. Narrative ethics for narrative care. *J Aging Stud* 2015; 34: 183–189.
29. Frank AW. Truth telling, companionship, and witness: an agenda for narrative ethics. *Hastings Cent Rep* 2016; 46(3): 17–21.
30. Johns C. *Guided reflection: a narrative approach to advancing professional practice*. Hoboken, NJ: John Wiley & Sons, 2011.
31. Artioli G, Foà C and Taffurelli C. An integrated narrative nursing model: towards a new healthcare paradigm. *Acta Biomed* 2016; 87(4S): 13–22.
32. Ö N, Britten N, Lloyd H, et al. The potential and pitfalls of narrative elicitation in person-centred care. *Health Expect* 2020; 23(1): 238–246.
33. Scheffelaar A, Janssen M and Luijkx K. The story as a quality instrument: developing an instrument for quality improvement based on narratives of older adults receiving long-term care. *Int J Environ Res Publ Health* 2021; 18(5): 2773.
34. Woelders S and Abma TA. Participatory action research to enhance the collective involvement of residents in elderly care: about power, dialogue and understanding. *Action Res* 2019; 17(4): 528–548.
35. Kara H. *Creative research methods in the social sciences: a practical guide*. Bristol: Policy Press, 2015.
36. Braun V and Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006; 3(2): 77–101.
37. Zaner RM. *Conversations on the edge: narratives of ethics and illness*. Georgetown University Press, 2004.
38. Zaner RM. *Ethics and the clinical encounter*. Lima, OH: Academic Renewal Press, 2003.
39. Montello M. Narrative ethics. *Hastings Cent Rep* 2014; 44(s1): 2–6.
40. Van Der Dam S, Molewijk B, Widdershoven GAM, et al. Ethics support in institutional elderly care: a review of the literature. *J Med Ethics* 2014; 40: 625–631.
41. van der Dam S, Abma TA, Kardol MJM, et al. "Here's my dilemma". Moral case deliberation as a platform for discussing everyday ethics in elderly care. *Health Care Anal* 2012; 20: 250–267.
42. Dauwerse L, van der Dam S and Abma TA. Morality in the mundane: specific needs for ethics support in elderly care. *Nurs Ethics* 2012; 19(1): 91–103.
43. Cirka CC and Messikomer CM. CARING for workers, caring for clients everyday ethics in assisted living. *Ethics and HRM*. 2006; 10: 129–158.
44. Powers BA. Ethnographic analysis of everyday ethics in the care of nursing home residents with dementia: a taxonomy. *Nurs Res* 2001; 50(6): 332–339.
45. Sion KYJ, Heerings M, Blok M, et al. How stories can contribute towards quality improvement in long-term care. *Gerontol*. 2023; Jul 1: gnad084.
46. Abma TA and Stake RE. Science of the particular: an advocacy of naturalistic case study in health research. *Qual Health Res* 2014; 24(8): 1150–1161.
47. Olmos-Vega FM, Stalmeijer RE, Varpio L, et al. A practical guide to reflexivity in qualitative research: AMEE guide No. 149. *Med Teach* 2023; 45: 24.